Harris EYE CARE

INTERIM MEDICAL HISTORY

Please fill out completely using black ink only.

Name _____ Date _____

Date of **last eye exam** (with complete medical history): _____

What **medications** do you currently take (prescription and over-the-counter): _____

_____

_____

Do you have **new allergies** to any medications, *since your last visit*? **YES** **NO**

If **YES**, list the medications: _____

Name of Medical Doctor: _____

Have you had any **major illnesses** or **injuries** *since your last visit*? _____

_____

Have you had any **surgeries** *since your last visit*? _____

_____

Do you ***currently*** have any problems in the following areas? If YES, please provide information.	YES	NO
EYES (blur, glare, red, pain, etc.)		
GENERAL/CONSTITUTIONAL (fever, weight loss, etc.)		
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)		
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)		
RESPIRATORY (asthma/bronchitis/COPD, etc.)		
GASTROINTESTINAL (acid reflux, etc.)		
KIDNEY, BLADDER (frequent urination, etc.)		
MUSCLES, BONES, JOINTS (joint pain, arthritis, etc.)		
SKIN		
NEUROLOGICAL (numbness, multiplesclerosis etc.)		
PSYCHIATRIC (anxiety, depression)		
ENDOCRINE (diabetes, thyroid, etc.)		
BLOOD/LYMPH (cholesterolemia, anemia, etc.)		
ALLERGIC/IMMUNOLOGIC (sneezing, redness, itching, hives, etc.)		

FAMILY HISTORY

Any *changes* to family medical status (mother, father, sibling, grandparent)?

If **YES**, please describe: _____

SOCIAL HISTORY

Changes in employment: _____

Changes in marital status: _____

Do you drink alcohol?	**YES**	**NO**	If **YES**:	occasional	1/day	2-3/day	4+/day
Do you smoke?	**YES**	**NO**	If **YES:**	occasional	$^1/_2$ pack /day	1 pack/day	1+pack/day

Patient Signature _____ *Date* _____

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