

SPRING HILL EYE CENTER

INTERIM MEDICAL HISTORY

Name: _____ Date _____

Reason for visit _____ Date of last eye exam _____

List current medications: _____

List allergies: _____

Have you had any **major illnesses or injuries** since your last visit? YES NO
 If yes, please list: _____

Have you had any **surgeries** since your last visit? YES NO
 If yes, please list: _____

Do you currently have any problems in the following areas? A "yes" or "no" must be checked. If YES, please provide information.

	Yes	No	Explanation of Problem
EYES			
GENERAL			
EAR,NOSE,THROAT			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES,JOINTS,BONES			
SKIN			
NEUROLOGICAL			
PSYCHIATRIC			
ENDOCRINE			
BLOOD, LYMPH			
ALLERIC,IMMUNOLOGIC			

FAMILY

Any changes to family medical status (parent,sibling,grandparent,child /glaucoma,diabetes,other)?
 YES NO If yes, describe: _____

SOCIAL

Any changes in employment? _____ Marital Status _____
 Do you drive? YES NO If so, do you have any visual difficulties while driving? YES NO
 Do you have problems with night driving? YES NO
 Do you currently wear contact lenses? YES NO If yes, how long? _____
 Do you currently wear glasses? YES NO If yes, how old are they? _____
 Do you drink alcohol? YES NO If yes: occasionally 1 per day 2-3 per day 4+ per day
 Do you smoke? YES NO If yes: occasionally 1/2 pack/day 1 pack/day 1+ pack/day

Patient/Guardian Signature _____ Date _____

Tech notes:

Tech _____ Physician Signature _____ Date _____