SPRING HILL EYE CENTER

INTERIM MEDICAL HISTORY

Name: _____Phone _____ Date _____

Reason for visit _____Date of **last eye exam**_____

List current medications & vitamins (strength & dose) _____

_____

_____

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			
CONSTITUTION/GENERAL			
CARDIOVASCULAR			
EAR,NOSE,THROAT			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES,JOINTS,BONES			
INTEGUMENTARY/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 ½ pack/day 1 pack/day 1+ pack/day

Patient/Guardian Signature _____ Date _____
Tech notes:

Tech _____ Physician Signature _____ Date _____