MEDICAL HISTORY

Date:_____
Name:_____

Have you noticed any changes in vision: YES: _____ NO: _____
If yes: please describe:

_____

What ***new medications*** (RX and OTC) do you currently take:

_____

Do you have any ***new allergies*** to medication since your last visit: YES: _____ NO:_____
If yes: please list_____

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: If "YES" please provide information

	YES	NO	EXPLANATION OF PROBLEM
EYES			
GENERAL/CONSTITUTIONAL			
EARS, NOSE,THROAT			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL,KIDNEY,BLADDER			
MUSCLES,BONES,JOINTS			
SKIN			
NEUROLOGICAL			
PSYCHIATRIC			
ENDOCRINE			
BLOOD,LYMPH			
ALLERGIC,IMMUNOLOGIC			
OTHER			

FAMILY: Any changes to family medical status (mother,father,siblings,grandparent) YES:_____ NO:_____
If yes, describe: _____
SOCIAL:
Changes in employment: _____Marital Status_____
Do you drive: YES: _____ NO: _____ Do you have difficulty when driving at night: YES: _____ NO:_____
Do you have visual difficulty when driving: YES: _____ NO: _____
Do you drink alcohol? YES: _____ NO: _____
Do you smoke? YES: _____ NO: _____

Patient's signature: _____