INTERIM MEDICAL HISTORY

Date_____

Name_____ Height _____

List all medications that you take (Prescription and over-the-counter) Weight _____

Medication Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any ***allergies*** to medication and if so, what was your reaction? ❑YES ❑NO

_____ _____ _____

_____ _____ _____

Have you had any ***surgeries, major illness, or injury*** since your last visit? ❑YES ❑NO

_____

Do you ***currently*** have any problems in the following areas? If "YES", please provide

	YES	NO	Explanation of Problem
EYES			
GENERAL/CONSTITUTION			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN			
DIABETES/HIGH CHOLESTEROL			
BLOOD/LYMPH			
ALLERGIC/IMMUNE			
FLOATERS/FLASHES OF LIGHT			
NEUROLOGICAL/PSYCHIATRIC			

Any ***changes*** to family medical status (mother, father, sibling, grandparent)? ❑YES ❑NO

If YES, please describe _____

Do you drive? ❑YES ❑NO

Do you have visual difficulty when driving? ❑YES ❑NO

Do you have problems with night vision? ❑YES ❑NO

Do you drink alcohol? ❑YES ❑NO If YES: occasional 1 per day 2-3 per day 4+ per day

Do you smoke tobacco? ❑YES ❑NO If YES: occasional ½ pack per day 1 pack per day 1+ per day

If NO: when did you quit? _____

Asthma: Using Medications? ❑YES ❑NO

High Blood Pressure: Last pressure reading _____

Diabetes: Latest blood sugar count _____ Is it under control? _____

Have you ever had a blood transfusion? ❑YES ❑NO Is it under control? _____

Have you ever had a sexually transmitted disease? ❑YES ❑NO Last A1c _____

If under 2 years of age: Immunizations up to date? ❑YES ❑NO

If over 65 of age: Pneumonia Vaccination? ❑YES ❑NO

High Risk Medication? ❑YES ❑NO

Physician's Signature _____ Date _____