INTERIM MEDICAL HISTORY 11/2014

Name: ________________________ **Date**: _________ **Date of Birth**:_____________ **Age**: _______

Date of LAST EYE EXAM (***WITH COMPLETED MEDICAL HISTORY & MEDS***): ________________

CURRENT ADDRESS:
____

BEST PHONE NUMBER TO CONTACT: ____
EMAIL: ____

DO YOU GIVE PERMISSION FOR DR. SINGH TO DO A COMPLETE MEDICINE RECONCILLIATION? *(This is done for your protection in regard to possible drug interaction.)*
YES / NO

PLEASE LIST ALL MEDICATIONS you currently take (*prescription & over the counter*):
(If you have a list, we can make a copy of it.)
____
____
____

Do you have **NEW ALLERGIES** to any medications, *since your last visit*? **YES** **NO**
If YES, list the medications: ____
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	DETAILS
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 BP, racing pulse, etc.)	_____	_____	____
RESPIRATORY (congestion, wheezing, etc.)	_____	_____	____
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)	_____	_____	____
GENITAL, KIDNEY, BLADDER (painful or frequent urination, impotence, etc.)	_____	_____	____
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps)	_____	_____	____
SKIN (pimples, warts, growths, rash, etc.)	_____	_____	____
NEUROLOGICAL (numbness, headache, etc.)	_____	_____	____
PSYCHIATRIC (anxiety, depression, insomnia)	_____	_____	____
ENDOCRINE (diabetes, hypothyroid, etc.)	_____	_____	____
BLOOD/LYMPH (cholesterolemia, anemia, etc.)	_____	_____	____
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)	_____	_____	____

FAMILY HISTORY
Any changes to family medical status (mother, father, sibling, grandparent)? **YES** **NO**
If YES, please describe: ____

SOCIAL HISTORY
Changes in employment: ____
Changes in marital status: ____
Changes in living arrangements: ____
Changes in driving habits: ____

Do you drink alcohol?	YES	NO	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?	YES	NO	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Physician's Signature: ______________________________________ **Date:** ________________