INTERIM MEDICAL HISTORY

Name_____**date**_____

Date of last eye exam _____

List all prescription medications you currently take: _____

_____

List all over-the-counter medications and vitamins you take: _____

_____

List all allergies to medications: _____

Have you <u>ever</u> been exposed to or diagnosed with tuberculosis? yes no

Do you have: chronic cough—yes no night sweats—yes no recent weight loss—yes no

List all major illnesses or injuries (diagnosis of cancer, diabetes, high blood pressure, etc.)

_____

List all surgeries you have ever had: _____

Are you pregnant or is there any possibility you could be pregnant? yes no

Do you currently have any problems in the following areas? (Circle yes or no) if yes, explain:

high blood pressure	yes	no	
general/constitutional (fever, etc)	yes	no	
ear, nose, throat	yes	no	
cardiovascular, heart problems	yes	no	
respiratory/breathing	yes	no	
gastrointestinal/stomach	yes	no	
muscles/bones/joints	yes	no	
skin	yes	no	
neurological (nerve disorders)	yes	no	
psychiatric	yes	no	
endocrine (diabetes, thyroid, etc)	yes	no	
blood, lymph (anemia, etc)	yes	no	
allergic, immunologic	yes	no	

Family medical status:_____

(List any medical diagnoses of mother, father, sibling, grandparent, child, such as: mom—high blood pressure, stroke; dad—heart attack, cancer, glaucoma, etc.)

SOCIAL:

changes in employment?_____

marital status (married, divorced, single, widowed)_____

living arrangements (alone, with family member, nursing home, etc.)_____

do you drive? yes no if yes, 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/day 2-3/day 4+/day

do you smoke? yes no if yes: occasional ½ pack/day 1 pack/day 1+ pack/day

Have you/anyone in your family ever been diagnosed with Creutzfelt-Jacob disease, Gerstmann-Straussler-Scheinker disease, Fatal Familial Insomnia, or any rapidly progressive dementia? (circle one) Yes No

Have you ever received hormones to increase your height? yes no

Have you ever received an organ or tissue transplant? yes no

Above history reviewed_____**date**_____