MEDICAL HISTORY & ROS

Date_____

Name_____ Date of **last eye exam**_____

What ***new*** **medications** (Rx & OTC) do you currently take?

_____

Do you have any ***new*** **allergies** to 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 you last visit?

_____

ROS: 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			

FAMILY
Any changes to family medical status (mother, father, sibling, grandparent)? _____YES _____NO
If YES, describe_____

SOCIAL
Changes in employment?_____

Marital Status (married, divorced, single, widowed)____

Living arrangements____

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 / day 4+ / day

Do you smoke? _____YES _____NO If YES: occasional ½ pack/day 1 pack/day 1+ pack

LIST ANY DRUG ALLERGIES:

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form:

REVIEWED:

Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection			

Physician's Signature____