INTERIM MEDICAL HISTORY

Today's Date: ____________ Date of last visit: _______________

Patient's Name: ____ **Referring Doctor:** ____________________________________

Pharmacy contact information: ____._____

What **medications** (prescriptions and over-the-counter) do you currently take?

____

Do you have any **allergies to medications**? ( ) **Yes** ( ) **No** If YES, please list the medications:

____

Please list any **major illnesses** or **injuries** that you have:

____

Have you had any **surgeries**?

____

Do you ***currently*** have any problems in the following areas? If YES please explain.

	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/IMMUNOLOGICAL			

Is there any chance you may be **pregnant**? ( ) **Yes** ( ) **No**

Are you currently breast feeding? ( ) **Yes** ( ) **No**

Do you **smoke** cigarettes? ( ) **Yes** ( ) **No**

Do you drink **alcohol**? ( ) **Yes** ( ) **No**

Have you had the **pneumococcal vaccine**? ( ) **Yes** ( ) **No**

Did you get the **flu vaccine** this year? ( ) **Yes** ( ) **No**

Do you **drive**? ( ) **Yes** ( ) **No**

Have you **fallen** this past year? ( ) **Yes** ( ) **No**

FAMILY HISTORY	**Yes**	**No**	**EXPLANATION OF PROBLEM**
BLINDNESS			**M**=mother **F**=father **S**=sibling **GM**=grandmother **GF**=grandfather
GLAUCOMA			**M F S GM GF**
ARTHRITIS			**M F S GM GF**
CANCER			**M F S GM GF**
DIABETES			**M F S GM GF**
HEART DISEASE			**M F S GM GF**
KIDNEY DISEASE			**M F S GM GF**
THYROID DISEASE			**M F S GM GF**
LUPUS			**M F S GM GF**
STROKE			**M F S GM GF**
OTHER			**M F S GM GF**

The Doctors of New York Cornea, PLLC usually do not prescribe glasses. We ask that you have your optometrist or primary ophthalmologist prescribe your glasses. However, should a glasses prescription need to be written by one of our doctors, I understand that I am responsible to pay a refraction fee of $50 to New York Cornea, PLLC at the time of my visit.

Patient's signature: ____ Date: ____________________

Physician's signature: ____ Date: ___________________