JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.

INTERIM MEDICAL HISTORY

NAME: ______________________ **DATE:** __________

Date of **last eye exam** (with complete medical history) ______________________

What **new medications** do you currently take (prescription and over-the-counter):

(cite exam where most recent complete list of meds is documented) ______________________

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 urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (high cholesterol, 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:* __________

"Mending Fences for Your Vision"