

Medical History Update

Last updated: _____

Patients Name _____ Date of Birth _____ Today's Date _____

Medications

List any medications you are currently taking, including eye drops:

Allergies

Since your last medical history update, have you developed any new allergies to medications or other substances? If so please explain:

Surgeries

Since your last medical history update, list all surgeries you have had:

Family History

Since your last medical history update, list any diseases that run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration):

General/Constitutional

Since your last medical history update, have you developed problems with any of the following:

YES NO If "YES" please explain:

Ear/nose/throat (hearing loss, sinus, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (irregular blood pressure, chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)..	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary (pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (muscle aches, swollen or painful joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (numbness, paralysis, headaches).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (unexplained weight loss, fever, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have diabetes? YES NO If yes, how many years? _____

Is your visit here related to a work injury? YES NO

Do you smoke? YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

Physician Signature _____ Date _____