MID ISLAND EYE
PHYSICIANS & SURGEONS

PATIENT HISTORY UPDATE

Your Name _____ Today's Date _____

Any NEW MEDICATIONS (prescribed or over-the-counter) since your last visit? ❑ Yes ❑ No
If YES, please list: _____

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 these areas? If "YES" please provide information: **IF "NO", PLEASE CHECK HERE:** ❑

	YES	Description 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		
OTHER		

FAMILY
Any Changes to the family medical status (mother, father, sibling, grandparent)? ❑ Yes ❑ No
If YES, describe _____

SOCIAL
Marital Status (married, divorced, single, widowed) _____

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 per day 4+/day
Do you smoke? ❑ Yes ❑ No: if YES: occasional ½ per day 1 per day 1+/day

Physician's Signature: _____ Date: _____