HISTORY UPDATE FORM

Name: _____ Date:_____

Please record any changes since your last exam with us

Reason for visit today:_____

What ***NEW*** medications do you currently take (prescription and over the counter)? :

_____

Do you have any ***NEW*** Drug Allergies? : **Yes**_____ **No**_____

If ***YES*****,** please list them:

_____

Reaction & Severity (mild, moderate, severe):

_____

Have you had any ***SURGERIES*** since your last visit? :

_____

Have you had any *major* ***INJURIES/ ILLNESSES*** since your last visit? :

_____

Do you currently have any *NEW* problems in the following areas?:

Eyes	○ **Yes**	○ **No**	
General/Constitutional	○ **Yes**	○ **No**	
Ears, Nose, Throat	○ **Yes**	○ **No**	
Cardiovascular	○ **Yes**	○ **No**	
Respiratory	○ **Yes**	○ **No**	
Gastrointestinal	○ **Yes**	○ **No**	
Genital, Kidney, Bladder	○ **Yes**	○ **No**	
Muscles, Bones, Joints	○ **Yes**	○ **No**	
Skin	○ **Yes**	○ **No**	
Neurological	○ **Yes**	○ **No**	
Psychiatric	○ **Yes**	○ **No**	
Endocrine	○ **Yes**	○ **No**	
Blood/Lymph	○ **Yes**	○ **No**	
Allergic/Immunologic	○ **Yes**	○ **No**	

FAMILY HISTORY: Any changes to family medical status (Mother, father, siblings, grandparents)? :

SOCIAL HISTORY:

Changes in employment: _____

Any interest in LASIK? **Yes**_____ **No**_____

Do you currently wear contacts? **Yes**_____ **No**_____ If ***NO*** are you interested in contacts? **Yes**_____ **No**_____

Do you wear sunglasses? **Yes**_____ **No**_____

Do you have problems with night vision or glare? **Yes**_____ **No**_____

Do you drink alcohol? **No**____ **Occasional**____ **1/Day**_____**2-3/Day**_____**4+/Day**_____

Do you smoke? **No**____ **Occasional**____ **½ Pack/Day**_____ **1 Pack/Day**_____ **1+ Pack/Day**_____

If ***NO*** have you ever smoked? **Yes**_____ **No**_____