

# Eye Physicians of Central Florida

## A Division of Florida Pediatric Associates, LLP

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**Interim Medical History Questionnaire**

**Date:** \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Please list any new eye problems since last exam:

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Please list any medications you currently take (prescription and over the counter):

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Do you have any allergies or reactions to medications? No Yes (explain)

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Please list any major illnesses or injuries since your last exam.

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Please list any surgeries you have had since your last exam.

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

Explanation or comments

Eye conditions or injuries	Yes	No	
General/Constitutional	Yes	No	
Ear, 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**

Explanation or comments

Any changes to family medical history? Yes No

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**Social History**

Changes in employment? Yes No

Changes in marital status? Yes No

Do you drive? Yes No

Do you have visual difficulty driving? Yes No

Do you have problems with night vision? Yes No

Do you drink alcohol? Yes No How many drinks per day?

Do you smoke? Yes No How many packs per day?

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

History reviewed:

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_