INTERIM HISTORY RECORD

Do you currently take any **NEW** medications since your last visit?

NO____ YES____ If yes, please list ____

Do you have any **NEW** allergies since your last visit?

NO____ YES___ If yes, please list____

Have you had any **surgeries** since your last visit?

NO___ YES___ If yes, please explain____

Have there been any changes **in your family's medical status**?

NO___ YES___ If yes, please explain____

Do you **currently** have any **problem** in the following areas?

If yes, please check with a brief explanation;

_____EYES____
_____FEVER/FATIGUE____
_____EAR/NOSE/THROAT____
_____CARDIOVASCULAR____
_____RESPIRATORY____
_____GASTROINTESTINAL ____
_____ GENITAL/KIDNEY/BLADDER_______________________________________
_____MUSCLES/JOINTS/BONES____
_____ SKIN ____
_____NEUROLOGICAL____
_____PSYCHOLOGICAL ____
_____ENDOCRINE ____
_____BLOOD/LYMPH ____

ARE YOU INTERESTED IN LASER VISION CORRECTION? YES ☐ NO ☐

DOCTORS SIGNATURE___________________________DATE ___________