INTERIM MEDICAL HISTORY

Name_____Date of Birth_____Date_____

List all prescription medications you currently take or provide a list <u>including dosage and frequency</u>:

_____

_____

_____

List all over-the-counter medications and vitamins you take: _____

_____

List all allergies to medications: _____

_____

List all surgeries you have ever had: _____

_____

Please answer the following questions:	SELF		(Family Member includes Father, Mother, Sibling, Grandparent or Child ONLY) Please describe any "YES" below:	Family Member	
	YES	NO		YES	NO
high blood pressure/high cholesterol					
general/constitutional (fever, etc)					
ear, nose, throat					
cardiovascular, heart problems					
respiratory/breathing/TB					
gastrointestinal/stomach					
muscles/bones/joints					
skin					
neurological (nerve disorders)					
psychiatric					
endocrine (diabetes, thyroid, etc)					
Glaucoma/Macular Degeneration					
Cancer					

SOCIAL:

changes in employment?_____

marital status (married, divorced, single, widowed)_____

living arrangements (alone, with family member, nursing home, etc.)_____

do you drive? yes no if yes, 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/day 2-3/day 4+/day

do you smoke? yes no if yes: occasional ½ pack/day 1 pack/day 1+ pack/day

do you have a living will/advance directive? yes no

Have you recently been outside the US? yes no Location_____

Have you ever received hormones to increase your height? yes no

Have you ever received an organ or tissue transplant? yes no

Are you pregnant or is there any possibility you could be pregnant? yes no

Above history reviewed_____date_____