KOKOPELLI EYE INSTITUTE

OUR VISION IS TO CARE ABOUT YOURS

Patient Medical History

Name:_____ _____
First Middle Last Nickname

What brings you in for examination, or what concerns do you have with your eyes?_____

Eye history, including surgeries:_____

Past medical history:_____

Past surgical history:_____

Family history of eye problems: Cataracts / Macular Degeneration /

Blindness / Glaucoma / Diabetes / Other:_____

Social history: Tobacco use (present/past) / Alcohol abuse /

Drug addiction / Other:_____

Have you any new or ongoing problems with the following review of systems: (circle None if no problems)

In General:_____ / None
Neurological:_____ / None
Skin:_____ / None
Ears:_____ / None
Nose :_____ / None
Respiratory:_____ / None
Cardiovascular:_____ / None
Gastro-intestinal:_____ / None
Genito-urinary:_____ / None
Musculoskeletal:_____ / None
Endorcrine:_____ / None
Immunological:_____ / None
Psychiatric:_____ / None

Eye medications / eye drops: _____
_____
_____

Other medications you take: _____
_____
_____
_____

Are you allergic to any medications, soaps, or topical iodine? yes / no

Please specify:_____