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

Endocrine: _____ / 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: _____