ARIZONA EYE INSTITUTE & COSMETIC LASER CENTER

NAME: _____ DATE: _____

What is the reason for your visit today? _____

_____

_____

Primary Care Doctor: Name, address, phone number: _____

_____

MEDICAL HISTORY

LIST ALL OF YOUR MEDICATIONS INCLUDING VITAMINS
AND ANY OVER THE COUNTER PAIN RELIEVERS OR HERBAL SUPPLEMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

LIST ANY EYE DROPS YOU INSTILL INTO YOUR EYES:

_____

_____

Are you allergic to any medications? PLEASE LIST ALL
OR WRITE NONE: _____

_____

_____

Date of last eye examination: _____

Do you wear contact lenses – NO YES (if yes) Type: Soft Rigid

Brand name, prescription information

_____

_____

Any history of eye surgeries or injuries? _____

_____

Any family history of glaucoma or macular degeneration?
If so whom? _____

_____

NO	YES	Scarring disorders
NO	YES	Liver, gall bladder problems
NO	YES	Hepatitis
NO	YES	Cancer – Type _____
NO	YES	Autoimmune disorders
NO	YES	Shingles, herpes or cold sores
NO	YES	Diabetes
NO	YES	Stroke, High blood pressure, heart problem
NO	YES	Stomach problems, indigestion or ulcers
NO	YES	Bleeding disorders
NO	YES	History of dry eyes
NO	YES	Thyroid problems
NO	YES	Psychiatric consultation
NO	YES	Abnormal chest X-rays
NO	YES	History of blood clots in legs or lungs
NO	YES	Back trouble
NO	YES	Asthma, COPD, Pneumonia, Tuberculosis
NO	YES	Smoke? How many per day? _____
NO	YES	Drink alcohol? How much? _____
		How often? _____
NO	YES	Are you pregnant or nursing?
NO	YES	Have you used Accutane in the last 6 month

Please list ALL surgeries you have had/year performed:

_____

_____

_____

PHARMACY INFORMATION:

Pharmacy Name & Location : _____

Phone Number: _____ Fax Number: _____

_____

_____ _____

PATIENT SIGNATURE

_____