LAKEVILLE EYE ASSOCIATES, LLC

Please complete the following:

Name: ______________________________________ Date: ________________________

Primary Care Doctor: _______________________________________

Known Allergies to Medications: ____

Current Eye Medications:____

Current Medications: ____

____

____

Known Current or Previous Eye Disease: ____________________________________

____

Previous Eye Surgery (other than by Dr. Kirber or Dr. Tantri):________________

____

Current or Previous Medical Conditions:

__High Blood Pressure __Diabetes __High Cholesterol

__Heart Disease __Asthma __COPD/Emphysema __Cancer of:

Other:____

____

Previous Surgeries:____

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Thank you for providing this information.