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VerdierEyeCenter.com

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MEDICAL HISTORY

Patient Name _____ Today's Date _____

Date of Birth _____ Date of Last Eye Exam _____ Height _____ Weight _____

Preferred Language: _____

Do you require the use of a wheelchair? Yes No If yes, can you transfer to an exam chair? Yes No

EYE MEDICATIONS: (include any prescriptions or over the counter medications)

1. _____ 2. _____ 3. _____ 4. _____
 5. _____ 6. _____ 7. _____ 8. _____

OTHER MEDICATIONS: (include any prescriptions or over the counter medications)

1. _____ 2. _____ 3. _____ 4. _____
 5. _____ 6. _____ 7. _____ 8. _____
 9. _____ 10. _____ 11. _____ 12. _____

Please bring your eye medications and current glasses with you, as well as a list of your other medications

ARE YOU ALLERGIC TO ANY MEDICATIONS?

No Yes If YES please list the medications and adverse reactions: _____

ANY ADVERSE REACTIONS TO ANESTHESIA?

No Yes If YES please explain: _____

HAVE YOU HAD ANY SURGERIES? Yes No

If YES please list all operations (cataract, appendectomy etc.): _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? Please check all that apply:

YES NO EYE HISTORY

<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses
<input type="checkbox"/>	<input type="checkbox"/>	Glasses
<input type="checkbox"/>	<input type="checkbox"/>	Poor reading vision
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye
<input type="checkbox"/>	<input type="checkbox"/>	Crossed eye
<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment
<input type="checkbox"/>	<input type="checkbox"/>	Poor distance vision
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration

Other: _____

YES NO HEALTH HISTORY

<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Headaches

Other: _____

YES NO FAMILY HISTORY

<input type="checkbox"/>	<input type="checkbox"/>	Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Corneal Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Corneal Transplants
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Color Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Retinal disease or detachment
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

Other: _____

ADDITIONAL INFORMATION: Use back of sheet to provide any additional information which may be important to your health care.

Primary Care Physician: _____ Office: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Printed Patient Name

Date

Signature of Patient / Guardian

Date

Signature of Reviewing Technician

Date

Signature of Reviewing Physician

Date