Verdier Eye Center

1000 East Paris Ave SE
Suite 130 & 150 Grand Rapids, MI 49546
Phone: (616) 949-2001 Fax: (616) 949-8620

VerdierEyeCenter.com

David D. Verdier, M.D.
Karl J. Siebert, M.D.
Ann M. Renucci, M.D., F.A.C.S.
Kyle B. McKey, M.D.
Roman I. Krivochenitser, M.D.
Radwa Elsharawi, M.D.
Troy L. Fox, O.D., F.A.A.O.
Brittany A. Darnley, O.D.
Jordan L. Marentette, O.D., F.A.A.O.
Derek M. Phelps, O.D.

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
☐	☐	Contact lenses
☐	☐	Glasses
☐	☐	Poor reading vision
☐	☐	Glaucoma
☐	☐	Lazy eye
☐	☐	Crossed eye
☐	☐	Keratoconus
☐	☐	Cataracts
☐	☐	Dry eyes
☐	☐	Retinal Detachment
☐	☐	Poor distance vision
☐	☐	Macular Degeneration

Other: _____

YES	NO	HEALTH HISTORY
☐	☐	Diabetes
☐	☐	Stroke
☐	☐	Cancer
☐	☐	Emphysema
☐	☐	Heart Disease
☐	☐	High Blood Pressure
☐	☐	Asthma
☐	☐	Thyroid Disease
☐	☐	Rheumatoid Arthritis
☐	☐	Depression
☐	☐	HIV/AIDS
☐	☐	Headaches

Other: _____

YES	NO	FAMILY HISTORY
☐	☐	Blindness
☐	☐	Corneal Dystrophy
☐	☐	Corneal Transplants
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Color Blindness
☐	☐	Lazy Eye
☐	☐	Crossed Eyes
☐	☐	Retinal disease or detachment
☐	☐	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