Verdier Eye Center

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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
☐	☐	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