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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	YES	NO	HEALTH HISTORY	YES	NO	FAMILY HISTORY
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Poor reading vision	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Transplants
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Crossed eye	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Color Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Retinal disease or detachment
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Poor distance vision	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS			
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Headaches			

Other: _____ Other: _____ 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 _____