Verdier Eye Center

1000 East Paris Ave SE
Suite 130 &130A 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.
Troy L. Fox, O.D., F.A.A.O.
Derek M. Phelps, O.D.
Brittany A. Darnley, O.D.

MEDICAL HISTORY

Patient Name _____ Today's Date _____

Date of Birth _____ Date of Last Eye Exam _____ Height_____ Weight_____

EYE MEDICATIONS:

_____

_____

_____

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

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

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No

If YES please list the medications: _____

ANY ADVERSE REACTIONS TO ANESTHESIA? ☐ Yes ☐ No

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
☐	☐	Corneal Dystrophy
☐	☐	Blindness
☐	☐	Corneal Transplants
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Color Blindness
☐	☐	Lazy Eye
☐	☐	Crossed Eyes
☐	☐	Retinal disease or detachment
☐	☐	Diabetes

Other:

Verdier Eye Center

1000 East Paris Ave SE
Suite 130 &130A 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.
Troy L. Fox, O.D., F.A.A.O.
Derek M. Phelps, O.D.
Brittany A. Darnley, O.D.

MEDICAL HISTORY

Patient Name _____ Today's Date _____

Date of Birth _____ Date of Last Eye Exam _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

Please check all that apply:

SOCIAL HISTORY

CONSTITUTIONAL	☐ Weight Loss	☐ Fevers	☐ Fatigue	
	☐ Weight Gain	☐ Weakness	☐ Night Sweats	
EYE	☐ Blurry Vision	☐ Eye Pain	☐ Eye Redness	☐ Decrease In Vision
	☐ Double Vision	☐ Eye Discharge	☐ Dry Eyes	
ENT	☐ Sore Throat	☐ Hearing Loss	☐ Nasal Congestion	☐ Vertigo
	☐ Lump In Neck	☐ Tinnitus	☐ Sinus Problems	☐ Hoarseness
CARDIOVASCULAR	☐ Rapid Heart Rate	☐ Chest Pressure/ Discomfort	☐ Irreg. Heartbeats/ Palpitations	
	☐ Heart Murmur	☐ Calf Pain	☐ Swelling In The Legs Or Feet	
RESPIRATORY	☐ Shortness Of Breath	☐ Chronic Cough	☐ Asthma	
	☐ Wheezing	☐ Coughing Up Blood		
SKIN	☐ Rash	☐ Hair Loss	☐ Ulcers	☐ Skin Lesions
	☐ Hives	☐ Skin Sores	☐ Skin Changes	☐ Skin Nodules
	☐ Dry Skin	☐ Itching Skin	☐ Nail Changes	
MUSCULOSKELETAL	☐ Joint Swelling	☐ Joint Pain	☐ Fractures	☐ Back Pain
	☐ Muscle Cramping	☐ Muscle Weakness	☐ Joint Stiffness	
ENDOCRINE	☐ Excessive Thirst	☐ Cold Intolerance	☐ Excessive Urination	
	☐ Excessive Hunger	☐ Heat Intolerance		
NEUROLOGICAL	☐ Seizures	☐ Migraines/ Headaches	☐ Dizziness	☐ Slurred Speech
	☐ Tremors	☐ Numbness	☐ Loss Of Balance	☐ Stroke
	☐ Memory Difficulty			
IMMUNOLOGIC	☐ Environmental Allergies	☐ Tender Lymph Nodes	☐ Seasonal Allergies	
HEM/LYMPHATIC	☐ Bruising	☐ Swollen Lymph Nodes	☐ Food Allergies	☐ Bleeding

ADDITIONAL INFORMATION:

Use this space 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: _____

Signature of Reviewing Physician Date

Printed Patient Name Date

Signature of Reviewing Technician Date

Signature of Patient / Guardian Date