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__________

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