

Verdier Eye Center, PLC

1000 East Paris Ave., SE Suite 130

Grand Rapids, MI 49546

Patient Name: _____	Today's Date: _____
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Date of Birth: _____	Date of Last Eye Exam: _____
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Eye Medications:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

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

Other Medication: (include any prescriptions or over the counter medications)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

6. _____ 7. _____ 8. _____ 9. _____ 10. _____

Are you **allergic** to any medications? **YES or NO**

If **yes** please list the medications: _____

Any adverse reactions to **anesthesia**? **YES or NO** If yes please explain: _____

Please list **all operations** (cataract, appendectomy, etc): _____

Past Medical History

Y N Eye History	Y N Health History	Y N Family History
<input type="checkbox"/> <input type="checkbox"/> Contact lenses	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Corneal Dystrophy
<input type="checkbox"/> <input type="checkbox"/> Glasses	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Blindness
<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 known medical problems: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____