Verdier Eye Center, PLC

1000 East Paris Ave., SE Suite 130
Grand Rapids, MI 49546

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

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
☐ ☐	Contact lenses
☐ ☐	Glasses
☐ ☐	Poor reading vision
☐ ☐	Glaucoma
☐ ☐	Lazy eye
☐ ☐	Crossed eye
☐ ☐	Keratoconus
☐ ☐	Cataracts
☐ ☐	Dry eyes
☐ ☐	Retinal Detachment
☐ ☐	Poor distance vision
☐ ☐	Macular Degeneration

Other:_____

_____

_____

_____

Y N	Health History
☐ ☐	Diabetes
☐ ☐	Stroke
☐ ☐	Cancer
☐ ☐	Emphysema
☐ ☐	Heart Disease
☐ ☐	High Blood Pressure
☐ ☐	Asthma
☐ ☐	Thyroid Disease
☐ ☐	Rheumatoid Arthritis
☐ ☐	Depression
☐ ☐	HIV/AIDS
☐ ☐	Headaches

Other:_____

_____

_____

_____

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

Other known medical problems:____

_____

_____

_____

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Social History

Tobacco: Never Smoked ☐ Ex-Smoker ☐ Current Smoker ☐
Alcohol Consumption: Never ☐ Occasional ☐ Frequent ☐

ROS	Y	N	Do you ***CURRENTLY*** have any problems in the following areas?
Constitutional			Weight loss ☐ Fevers ☐ Weakness ☐ Fatigue ☐ Weight gain ☐ Night Sweats ☐
EYE			Blurry vision ☐ Eye pain ☐ Eye discharge ☐ Eye Redness ☐ Decrease in vision ☐ Dry eyes ☐ Double Vision ☐
ENT			Sore Throat ☐ Lump in Neck ☐ Hearing loss ☐ Nasal Congestion ☐ Vertigo ☐ Tinnitus ☐ Sinus Problems ☐ Hoarseness ☐
Cardiovascular			Chest Pressure/ Discomfort ☐ Irreg. Heartbeats/ Palpitations ☐ Rapid heart Rate ☐ Heart murmur ☐ Calf Pain ☐ Swelling in the legs or feet ☐
Respiratory			Shortness of breath ☐ Chronic cough ☐ Asthma ☐ Wheezing ☐ Coughing Up Blood ☐
Skin			Rash ☐ Hives ☐ Hair loss ☐ Skin sores ☐ Ulcers ☐ Skin Changes ☐ Skin Lesions ☐ Skin Nodules ☐ Dry Skin ☐ Itching Skin ☐ Nail Changes ☐
Musculoskeletal			Joint Swelling ☐ Muscle Cramping ☐ Joint Pain ☐ Muscle Weakness ☐ Fractures ☐ Joint Stiffness ☐ Back pain ☐
Endocrine			Excessive Thirst ☐ Heat intolerance ☐ Cold intolerance ☐ Excessive Hunger ☐ Excessive Urination ☐
Neurological			Seizures ☐ Tremors ☐ Migraines/ Headaches ☐ Numbness ☐ Dizziness ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐ Memory Difficulty ☐
Immunologic			Environmental Allergies ☐ Food Allergies ☐ Seasonal Allergies ☐
Hem/Lymphatic			Bruising ☐ Swollen Lymph Nodes ☐ Tender Lymph Nodes ☐ Bleeding ☐

Primary Care Physician and Office Location:

Additional Information: Use this space to provide any additional information which may be important to your health care.

Signature of Reviewing Physician Date

Printed Patient Name Date

Signature of Reviewing Technician Date

Signature of Patient / Guardian Date