

**OFFICE OF PECOS T. OLURIN M.D.**

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OPHTHALMIC HISTORY FORM

Please cooperate with our efforts to better serve you by completing this form as accurately as possible

Name: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex M  F  Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ marital status Single  Married  Divorced  Widowed

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

List the problems that are the reason for this visit including associated non- eye related problems

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last ophthalmic exam: \_\_\_\_\_ by Dr. \_\_\_\_\_

Do you wear glasses or contacts? How old is your current prescription \_\_\_\_\_

What is your contact lens wear and replacement regimen? \_\_\_\_\_

**Medication Please list all medications that you are on at this time.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** Please list all known and suspected allergies, especially to medicines:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past personal and family Medical History: Please check all that apply

	YES	NO	FAMILY		YES	NO	FAMILY
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any pertinent medical issues that you think are relevant (INCLUDE PAST SURGERIES)

\_\_\_\_\_  
\_\_\_\_\_