

OFFICE OF PECOS T. OLURIN M.D.

1403 NORTH RODNEY STREET

WILMINGTON, DE 19806

PHONE 302.654.4800 FAX 302.654.4899

OPHTHALMIC HISTORY FORM

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

Name _____ Date of Birth? _____ Age _____

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

Date of last eye exam: _____ by Dr _____ Do you wear glasses or contacts? YES No

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 Medical History: Please check all that apply to you or close family members:

	YES	NO	Family History		YES	NO	Family History
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 (Rheumatoid)	<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 ALL PAST SURGERIES)

Do you currently smoke? YES No

Do you drink alcohol regularly YES No

Do you use now or have you used recreational drugs in the past (particularly IV drug use

YES No

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WORKMAN'S COMPENSATION/ ON THE JOB ACCIDENT

Patient name: _____ Date of Birth _____

Sex M F Social Security # _____ Age _____

Home Address: _____

City, State, and Zip: _____ - _____ - _____

Marital status: Single Married Divorced Widowed

Home phone: (_____) _____ Work phone: (_____) _____ ext. _____

Employer: _____ Occupation: _____

Employer address:

Spouse or emergency contact: _____

Supervisor: _____

Was this injury reported? No Yes If yes, to whom: _____

What was the date of the above work injury: _____

Insurance Company: _____

Address & Phone #: _____

Claim #: _____ Adjuster Name: _____

If you have an attorney, please provide name, address and telephone number:

ASSIGNMENT AND RELEASE

I, The undersigned certify that I (or my Employer) have WORKERS COMPENSATION insurance coverage with _____ and assign directly to Dr Pecos T. Olurin all insurance benefits, if any, other payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY OR PATIENT

DATE