O'Rourke VISION CARE

PATIENT INFORMATION

First Name:______________________MI:_______Last:________________________Nick Name:_________________Date:_________________

Address:____City__________________________State:____________________Zip___________

Home Phone: _____________________________Work Phone: ___________________________Cell Phone:_____________________________

E-Mail Address____ Male _____Female_____ DOB:__________________________________

Social Security #_______________________________________Marital Status____

Employer:____Occupation____

Name of Physician (PCP):____PCP Phone#:_____________________PCP Fax#_________________

How did you hear about our practice? ____

Health Insurance Co. _____________________________________ **Vision** Insurance Co. ____

Subscriber to your insurance(s)?________________________(Their)Birth Date:______________(Their) Social Security #___________________

Emergency Contact:_____________________________________Relationship:________________________Phone:_________________________

Ocular History Information

Date of last eye exam: ____________ Name of Previous Eye doctor _________________________________Do you wear glasses?__________

Do you wear contacts? _______ Are you interested in contacts? ______ Are you interested in Lasik? ______ Desired time frame? ___________

Do you currently experience/have any of the following? **If not check--None** ☐

Blurry Vision	☐	Dry, scratchy eyes	☐	Excessive Itching	☐	Retinal Detachment	☐	Cataracts	☐
Watery Eyes	☐	Light Sensitivity	☐	Double Vision	☐	Flashes/Floaters	☐	Glaucoma	☐
Eye pain/strain	☐	Headaches	☐	Eye/Head injury	☐	Macular Degeneration	☐	Eye Surgery	☐

Medical History

Please circle any conditions listed below that YOU have a history of? Or check-- NONE ☐

Anxiety	Circulatory Problems	Hepatitis/Liver Disease	Radiation Treatment
A.I.D.S/HIV	Convulsions	High Blood Pressure	Respiratory Problems/Disorders
Alcoholism	COPD	Hip or Joint replacement	Rheumatic Fever
Allergies	Depression	Jaundice	Rheumatoid Arthritis
Anemia	Diabetes	Kidney Disease	Scarlet Fever
Arthritis	Elevated Cholesterol	Kidney Dialysis	Seizures/Fainting Spells
Asthma	Epilepsy	Leukemia	Sinus Problems
Atrial Fibrillation (irreg. heartbeat)	Excessive Bleeding	Lupus	Stomach Ulcers
Benign Prostate Enlargement-BPH	GERD	Low Blood Pressure	Stroke
Blood Disease	Hay Fever	Lymphoma	Thyroid Disease
Bone Disease	Head Injuries	Malignancies	Tuberculosis
Cancer	Hearing Impaired	Mitral Valve Prolapse	Tumors or Growths
Chemical Dependency	Heart Disease	Neck & Back Problems	Ulcers
Chest Pain	Heart Valve/Murmur	Pacemaker	Venereal Disease

COMPLETE FRONT AND BACK

O'Rourke
VISION CARE

Date of your (patients) last medical exam:____________________________

List any medications including vitamins and any non-prescriptions:____

____

Do you have any medication allergies? __________ If yes, please list:____

List all surgeries/dates:____

Have you had a transplant that has depressed your immune system?______________________

WOMEN ONLY: Are you currently taking birth control?____ Are you nursing/breastfeeding?________

Is there a possibility of pregnancy?_______________Are you pregnant:_____________________________ Expected delivery date:_____________

Social History

Do you smoke?________________If so, how much?__________________________Have you ever?_____________When did you quit?__________

Do you drink?_________________if so, how much?______________________________Have you used recreational drugs?____________________

Family History

Are there any medical or eye diseases in YOUR FAMILY? If yes, PLEASE STATE FAMILY RELATIONSHIP If not, check None ☐

Glaucoma:__________________________________

Macular Degeneration:________________________

Retinal Detachment:__________________________

Turned or Lazy Eye:__________________________

Diabetes:___________________________________

High Blood Pressure:_________________________________

Heart Disease:______________________________________

High Cholesterol:____________________________________

Cancer:____

Stroke:____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise, payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of **ALL** services rendered on my behalf or my dependents.

Patient Signature: (or parent/guardian of minor)____Date:______________________

Office staff Initial