Loma Linda Optometry

Today's Date_____ **Last Eye Exam** _____ **Date of Birth**_____ **Gender** M F
First Name_____ **Middle Initial**_____ **Last Name**_____
Spouse (or Parent's Name)_____
Address_____
City_____**State**_____**Zip**_____ **Patient Social Security #**_____
Home Phone_____
Daytime Phone_____
Cell Phone_____ **Text Messages Okay?** *(circle)* Yes No
Email Address_____
Circle One: Single Married Widowed Divorced Separated

Preferred Language English Spanish
Race: *(please circle one)*
Caucasian Asian Hispanic/Latino Native American/Pacific Islander Black/African American Other

Preferred Method of Contact: *(circle one)* Phone Text Email Postal
Employer_____ **Occupation**_____
Full Time College Student? *(circle one)* Yes No **If Yes Which School?**_____

Do you currently wear: *(circle)* Glasses Contacts Readers
Frequency: *(Circle)* All the time Occasionally
Brand of Contacts: *(current wearers)*_____ **Type:** *(circle)* Daily Monthly Bi-weekly
Primary Care Physician_____ **PCP's Phone**_____
Current Medication *(including over the counter) (List below or attach list)*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any allergic reactions to medications or eye drops:

_____
_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only)

Disease/Condition	**Yourself**	
Cataract	yes	no
Eye Turn	yes	no
Glaucoma	yes	no
Macular Degeneration	yes	no
Retinal Detachment	yes	no

Women- are you pregnant?	yes	no
Women- are you breastfeeding?	yes	no

	Family Member		**Relationship (blood relatives only)**
Blindness	yes	no	_____
Eye Turn	yes	no	_____
Glaucoma	yes	no	_____
Macular Degeneration	yes	no	_____
Retinal Detachment	yes	no	_____
Other:			

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Review of Systems indicate below if you had problems in the last 6 months with any these conditions or any chronic conditions

Allergic/Immunologic
None
Lupus (SLE)
Rheumatoid Arthritis
Environmental Allergies
Seasonal Allergies
Other (ie. Latex)

Ear, Nose and Throat
None
Sinusitis
Upper Respiratory
Tract Infection
Other

Gastrointestinal
None
Crohn's Disease
Colitis
Acid Reflux/Ulcer
Other

Skin/Integumentary
None
Eczema
Rosacea
Psoriasis
Other

Psychiatric
None
Depression
Bi-Polar
Schizophrenia
Other

Cardiovascular
None
High Blood Pressure
Heart Disease
Stroke
Vascular Disease
High Blood Cholesterol

Endocrine/Glands
None
Diabetes
Hormone Dysfunction
Thyroid Dysfunction
Other

Respiratory
None
Asthma
Bronchitis
Emphysema
Other

Muscle/Skeletal
None
Arthritis
Fibromyalgia
Ankylosing Spondylitis
Other

Genital/Urinary
None
Urinary Tract Infection
HIV Positive
Herpes / Chlamydia
Other

Hematologic/Lymphatic
None
Anemia
Leukemia
Bleeding Disorder
Other

Neurological
None
Multiple Sclerosis
Epilepsy
Tremors
Other

General Health
None
Weight loss/gain
Fever
Fatigue
Trauma

Social
Tobacco Use (*Circle One*)
Current Smoker Former Smoker Non-Smoker
Non-Prescription Drugs_____
Alcohol Consumption_____
Height_____' _____" Weight_____lbs

Insurance Information

Insured's Name_____ Relationship to Patient_____
Insured's Employer_____ Insured's SS#_____
Insured's Date of Birth_____
Vision Insurance Plan_____ Vision Insurance ID#_____
Medical Insurance Plan_____ Medical Insurance ID#_____

Acknowledgment of Receipt of Notice of Privacy Practices

My signature below verifies that I have received a copy of the Loma Linda Optometry Notice of Practices for Loma Linda Optometry.

Name of Patient (Print)_____ Signature of Patient_____ Date_____
Signature of Patient Representative *(if patient is a minor or an adult unable to sign this form)*
Relationship of Patient Representative to Patient_____