Loma Linda Optometry

Previous Patient Update Form

Please mark any changes to your contact information below.
Address_____
_____
_____
Home Phone_____
Daytime Phone _____
Cell Phone_____
Email Address_____

Current Medication ***(only mark if you have changes to your medications)***
(including over the counter) (List below or attach list)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any allergic reactions to medications or eye drops:

_____
_____

Review of Systems

(please indicate below if you have had any of the following conditions within the last 6 months or any of these chronic conditions)

Allergic/Immunologic
Lupus (SLE)
Rheumatoid Arthritis
Environmental Allergies
Seasonal Allergies
Other (ie. Latex)

Ear, Nose and Throat
Sinusitis
Upper Respiratory
Tract Infection
Other

Gastrointestinal
Crohn's Disease
Colitis
Acid Reflux/Ulcer
Other

Skin/Integumentary
Eczema
Rosacea
Psoriasis
Other

Psychiatric
Depression
Bi-Polar
Schizophrenia
Other

Cardiovascular
High Blood Pressure
Heart Disease
Stroke
Vascular Disease
High Blood Cholesterol

Endocrine/Glands
Diabetes
Hormone Dysfunction
Thyroid Dysfunction
Other

Respiratory
Asthma
Bronchitis
Emphysema
Other

Muscle/Skeletal
Arthritis
Fibromyalgia
Ankylosing Spondylitis
Other

Genital/Urinary
Urinary Tract Infection
HIV Positive
Herpes/Chlamydia
Other

Hematologic/Lymphatic
Anemia
Leukemia
Bleeding Disorder
Other

Neurological
Multiple Sclerosis
Epilepsy
Tremors
Other

General Health
Weight loss/gain
Fever
Fatigue
Trauma

Social
Tobacco Use (*Circle One*)
Current Smoker Former Smoker Non-Smoker
Alcohol Consumption?_____ /week Non-Rx Drug Use?_____
Height___' ___" Weight_____lbs

Loma Linda Optometry

Insurance Information

Please fill out only if there are changes to your 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 previously received a copy of the Loma Linda Optometry Notice of Practices for Loma Linda Optometry upon a prior visit and a copy is available upon my request for another copy.

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_____

I certify that I have reviewed and updated all of my information _____ Date_____