LOMA LINDA OPTOMETRY

Today's Date _____ **Last Eye Exam** _____ **Date of Birth** _____ **Gender** M F

First Name:_____ **Middle Initial**_____ **Last Name** _____

Parent(Guardian) Name _____ **Patient SSN#** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Daytime Phone** _____

Cell Phone _____ **Text Message Okay? (***Circle One***)** Yes No

Email Address _____

Preferred Method of Contact: (*Circle One)* Phone Text Email Postal

Preferred Language English Spanish

Marital Status (*Circle One***):** Single Married Widowed Divorced Separated

Race: (*Circle one*)

Caucasian Asian Hispanic/Latino Native American/Pacific Islander Black/African American Other

Employer _____ **Occupation** _____

Do you currently wear: *(Circle All That Apply)* 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 medication or eye drops:

_____

_____

Please indicate if any of the conditions apply to you or your 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:	yes	no	_____

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Review of systems indicate below if you have had any problems in the last 6 months with any of 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
Alcohol Consumption? _____/week
Non-RX Drug Use? _____
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)
_____ Date _____
Relationship of Patient Representative to patient _____