**Don Holland, O.D.**

 Irvine Eye Care

 14210 Culver Drive, Suite F

Irvine, CA 92604

**Confidential Patient Information**

\*\*\*All sections must be completed in full to meet HIPAA compliance regulations.

Name (First, MI, Last):

Address: City State Zip

Home Phone: Cell: Work:

Email Address: Birth Date: Age:

Employer: Occupation:

Person to contact in an emergency: Phone:

Date of Last Exam: Reason for Today’s Exam:

**Insurance Information**

Name of Primary Member: Primary Member DOB:

Insurance Provider: ID # of Primary Member:

**Medical History**

 Do YOU have any history of the following?

 ⁭ Diabetes ⁭ Heart Condition ⁭ Macular Degeneration

 ⁭ High Blood Pressure ⁭ Cataract ⁭ Strabismus/Amblyopia (Turned/Lazy Eye)

 ⁭ Thyroid condition ⁭ Glaucoma ⁭ **CHECK IF NONE APPLY**

 Please list all medications you are currently taking:

 Are you allergic to medications? If so, please list: **If there are no changes to your medical or ocular history or medications, please initial here:**

Do you currently wear glasses? ⁭ Yes ⁭ No

 If so, when do you wear your glasses?

 ⁭ All the time ⁭ Reading/Near Work ⁭ Work Safety

 ⁭ Computer Work ⁭ Other (explain):

Do you currently wear contact lenses? ⁭ Yes ⁭ No

 If no, are you interested in wearing contact lenses? ⁭ Yes ⁭ No

Have you had LASIK surgery? ⁭ Yes ⁭No

If no, are you interested in laser vision correction? ⁭ Yes No

What hobbies or sports do you participate in?

X

Signature of Patient (or Parent if a Minor) Date