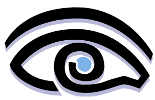

Welcome to Premier Eyecare

3911 Coffee Rd Bakersfield, CA 93308 ◊ John F. Hawley, OD. ◊ Cache M. Crawford, OD. ◊ Keith C. Miller, OD.

Today's Date____________________

Name____________________________________ ▫M ▫F

Street ____

City___________________ State_________ Zip___________

Home Phone ________________Work/Cell_____________

Date of Birth ________________________Age____________

Social Security # ___________________________________

Employer (or School)_________________________________

Occupation (or Grade) _______________________________

Spouse (or Parent's) Name____________________________

Spouse (or Parent's) Work____________________________

Email Address______________________________________

Can We contact you through email? ▫**Y** ▫**N**

Vision Benefit __________________________________

Subscriber Name ___________________________________

Subscriber Date of Birth_____________________________

Social Security #____________________________________

Secondary Vision Benefit __________________________

Name/DOB/SS#_____________________________________

Primary Medical Insurance__________________________

Subscriber Name ___________________________________

Subscriber Date of Birth_____________________________

Social Security #____________________________________

Date of Last Eye Exam ___________________________ Date of Last Physical Exam ____________________________

Name of Family Physician ____

What is your major purpose for this visit? (Check all that apply)

▫Eye Health Exam ▫New Glasses ▫Contact lenses ▫Other____

Do you currently wear glasses? ▫**Y** ▫**N**

Are there any problems with your current glasses?____

Do you wear contact lenses? ▫**Y** ▫**N** What kind? ____

Are there any problems with your current contact lenses?____

Would you like to renew your contact lens prescription today? ▫**Y** ▫**N**

Are you interested in trying contact lenses today? ▫**Y** ▫**N**

Patient Eye and Medical History

Are you currently experiencing any of the following eye or vision problems?

▫Blurred Vision ▫Vision Loss ▫Eye Allergies (itching)

▫Double Vision ▫Floaters/Flashes ▫Eye Turn (strabismus)

▫Foreign Body Sensation ▫Headaches ▫Red Eye/Dry Eye

Have you ever been diagnosed with any of the following eye disorders:

▫Amblyopia (Lazy Eye) ▫Glaucoma ▫Macular Degeneration

▫Iritis/Uveitis ▫Cataracts ▫Retinal Detachment

▫Strabismus (Eye turn) ▫Other_____________________________________

Eye Surgery/Injury: What kind?____________ When?________ Which eye(s) _____

Is there any family history of the following eye diseases?

▫Macular Degeneration ▫Glaucoma ▫Amblyopia (Lazy Eye)

▫Retinal Detachment ▫Keratoconus ▫Strabismus (Eye Turn)

▫Diabetic Retinopathy ▫Other_____________________________________

Is there any family history of the following systemic diseases?

▫Diabetes Relationship:_______________________________________

▫Hypertension Relationship:_______________________________________

Do you have any of the following medical conditions?

▫Allergies

▫High Blood Pressure

▫High Cholesterol

▫Heart Disease

▫Diabetes

▫Thyroid Disease

▫Kidney Disease

▫Arthritis

▫Skin/Dermatological

▫Neurological

▫Asthma

▫Cancer

▫Other_________________________

____

Current medications (prescription, non-prescription, vitamins, etc.) None ▫

Name:______________________________________ Name:______________________________________

Name:______________________________________ Name:______________________________________

Ocular Medications:____

Allergies to Medications ▫Yes ▫No Which ones?____

The information in this confidential case history form is critical to the evaluation of your vision health