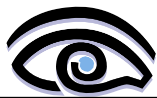

Welcome to Premier Eyecare

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/work Phone _____________ 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____
May we send messages to you through text & 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____
How many hours a day do you look at a Computer Screen and/or other Electronic Devices? _____________________
Do you currently wear glasses? ☐**Y** ☐**N**
Are there any problems with your current glasses?____
Do you wear contact lenses? ☐**Y** ☐**N** **What kind of lenses?** ☐ **Soft** ☐ **Hard** **Brand?** __________________
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:___________________________________
☐High Cholesterol 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