Welcome to Premier Eyecare

3911 Coffee Rd Bakersfield, CA 93308 ♦ John F. Hawley, O.D. ♦ Cache M. Crawford, O.D.

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?_____
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

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

Date_____ Reviewed_____
Date_____ Reviewed_____
Date_____ Reviewed_____