WELCOME TO AGAVE EYE CARE, PLLC

Mr./Mrs./Ms. _____ Birth Date _____ Age _____

LAST FIRST MI PREFERRED

Any change in address, phone #, e-mail or insurance? Yes___ No___

Please Note Changes Here:

_____

_____

_____

REASONS FOR TODAY'S VISIT

___ Want new glasses ___ Lost / Broke Glasses

__ Want new contact lenses ___ Try contact lenses (clear **OR** colored) ___ Try bifocal contact lenses

___ Having trouble seeing (Please Circle: **distance *OR* near *OR* both *OR* @ the computer)**

___ Other please explain:

_____

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS?

___ Blurred vision	___ Discharge	___ Double vision	___ Flashes; How often? _____
___ Burning / Stinging	___ Itching	___ Loss of vision	___ Floaters; How often? _____
___ Dryness / Sandy / Gritty	___ Pain / Soreness	___ Light sensitive	___ Other _____
___ Excessive tearing / watering	___ Redness	___ Eye fatigue	

___ Headaches: Where? Frontal / temporal / back of head

When? Early morning / afternoon / evening / weekdays / weekends / after school / after work

How often? Daily / _____ times per week / _____ times per month

Do you feel eye strain or soreness at the end of your workday? **Yes___ No___**

EYEWEAR HISTORY:

Are you seeing well with the glasses that were prescribed to you last year? **Yes___ No___ N/A ___**
If no, please explain:

_____

If you are a contact lens wearer, were the contact lenses that were prescribed last year still feel comfortable? **Yes___ No___**

Any change in personal medical or family medical and/or ocular History? Yes___ No___

Please Note Changes Here:

_____

_____

Any eye infection, injury, or surgery since the last visit? Yes___ No___

Any new allergy to medication and /or new medications? Yes___ No___

If yes, please list _____