WELCOME TO AGAVE EYE CARE, PLLC

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

LAST FIRST MI PREFERRED

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone: Home _____ Work/Mobile _____ E-Mail _____

Preferred Method of Contact (for recall): ___phone / e-mail___ (for notification of eyewear pick-up): ___phone / e-mail___

Employer _____ Occupation _____

How did you hear about our office? _____ If you were referred to our office, who may we thank? _____

Name of insurance plan _____ Name of primary insured _____

Birth Date of Primary Insured _____ ID # _____ Group # _____

Relationship to Patient _____

Approximately when was your last eye exam? _____ **Doctor's (or office) Name** _____

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:

_____

PERSONAL AND FAMILY EYE HISTORY

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
___ Excessive tearing/watering ___ Redness ___ Eye fatigue ___ OTHER _____

___ **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

Have you ever had an eye infection, or surgery, or injury? ***NO*** / ***YES*** If "YES", please explain _____

GLASSES HISTORY

Do you currently wear glasses? ***YES*** / ***NO*** ***FULL-TIME*** / ***PART-TIME*** (for driving only; for near / computer work only)

Do you wear sunglasses / do you have transition feature (darken outdoor)? ***YES*** / ***NO*** ***(OR TRANSITION)***

Does glare bother you (especially while you are driving, or while working on the computer or at your office desk)? ***YES*** / ***NO*** **If "YES", please explain** _____

At the end of your workday, do your eyes feel strained, sore, or tired? ***YES*** / ***NO***

****THE FOLLOWING INFORMATION WILL HELP THE DOCTOR PRESCRIBE APPROPRIATELY FOR YOUR LIFESTYLE.****

How many hours per day are you working on a computer? _____ (Intermittently / Consecutively)

If you wear glasses while using the computer, are they working well (visually and ergonomically)? ***NO*** / ***YES***
If no, please explain _____

Are you using computer lenses? ***YES*** / ***NO***
If you are not using the computer lenses, are you interest learning more about it? ***YES*** / ***NO***

What are your hobbies? Crossword puzzles, Cross-Stitching, Crochet, Drawing, Gardening, Knitting, Photography, Sewing, Reading, ***OTHER*** _____

What exercise/sports do you do on regular basis? Baseball / Softball, Basketball, Biking, Football, Lacrosse, Martial arts, Pilates, Running, Soccer, Swimming, Tai-Chi, Yoga, weight lifting, working out in the gym, ***OTHER*** _____

DO YOU OR YOUR RELATIVES HAVE ANY OF THE FOLLOWING CONDITIONS?

	NO	YES	WHO	
Amblyopia (lazy eye)	___	___	self / relative	_____
Cataract	___	___	self / relative	_____
Color Blindness	___	___	self / relative	_____
Glaucoma	___	___	self / relative	_____
Macular Degeneration	___	___	self / relative	_____
Retinal Conditions	___	___	self / relative	_____
Strabismus (eye turn)	___	___	self / relative	_____

PERSONAL AND FAMILY MEDICAL HISTORY

	NO	YES	WHO	WHICH RELATIVE	
AIDS/HIV	___	___	self / relative	_____	
Allergy	___	___	self / relative	_____	What type? _____
Arthritis	___	___	self / relative	_____	What type? _____
Auto-Immune condition	___	___	self / relative	_____	What type? _____
Blood disorder	___	___	self / relative	_____	What type? _____
Cancer	___	___	self / relative	_____	What type? _____
Diabetes	___	___	self / relative	_____	What type? _____
Gastrointestinal condition	___	___	self / relative	_____	What type? _____
Genitourinary condition	___	___	self / relative	_____	What type? _____
Heart disease	___	___	self / relative	_____	What type? _____
High Blood Pressure	___	___	self / relative	_____	
Kidney condition	___	___	self / relative	_____	What type? _____
Neurologic condition	___	___	self / relative	_____	What type? _____
Psychiatric condition	___	___	self / relative	_____	What type? _____
Respiratory condition	___	___	self / relative	_____	What type? _____
Skin condition	___	___	self / relative	_____	What type? _____
Stroke	___	___	self / relative	_____	
Thyroid disease	___	___	self / relative	_____	What type? _____

Are you a smoker? YES / NO

If female, are you pregnant and or nursing? YES / NO / N/A

Please list any medication or substances you are *ALLERGIC* to

_____

Please list any medication you are currently taking (i.e., oral, over the counter, nutritional supplements, and eye drops) _____

_____

_____