Dr Mark Lukito & Associates

Medical Questionnaire

*We welcome you to our practice and ask that you kindly complete all information on this sheet*

|  |  |
| --- | --- |
| Name  | Date of Birth  |
| Reason for your visit, please give details |
| Any history of…. | Check off all that apply…. | Are you interested in …. |
|  Self Family Glaucoma O O Cataracts O O Diabetes O O High Blood Pressure O O Macular Degeneration O O Heart problems O O Retinal Detachment O O Stroke O O Thyroid Condition O O Crossed/Lazy eyes O O Asthma/ Allergies O O Color Blindness O O Arthritis O O Tuberculosis O O HIV/ Hepatitis O O Cancer O O Neuromuscular O O Blindness O O Other ­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Blurry distance vision
* Poor night vision
* Eye Strain
* Blurry near vision
* Trouble reading
* Itchy Eyes
* Discharge
* Watering
* Pain in the eye
* Burning eyes
* Sandy or dry eyes
* Red eyes
* Glare/Reflection.Haloes
* Rainbows around the eyes
* Discomfort in brightness/sunlight
* Double vision
* Floaters or spots in your vision
* Flashes of light
* Dark spots in your vision
* An eye injury
* History of wearing an eye patch
* History of eye surgery
* Headaches
* Dental Abcess
* Legally blind
* Tired eyes
 | * New spectacles
* A new prescription
* Light weight glasses
* Anti- reflection coating
* Durability
* Ortho K
* Fashion
* Field of view
* Colored contact lenses
* Sunglasses, Clip ons
* Safety glasses
* Sports glasses
* Contact lenses
* Myopia control
* Refractive Surgery
* Dry Eye therapy

How were you referred to us* Family Doctor
* Another Patient
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

Please list any medications you take \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation / School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer / Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Thank you for completing this form***

***Dr Mark Lukito OD***