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***