# Stone Road Optometry

## 435 Stone Road West Unit 5A

We welcome you to our practice and ask that you kindly complete, or correct, all information on this sheet.

| Name_____ | DOB: |
|---|---|
| Please state the main reason for this visit: | |

Any history of....

| Self | Family | |
|---|---|---|
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Cataracts |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Macular Degeneration |
| ☐ | ☐ | Heart Problems |
| ☐ | ☐ | Retinal Detachment |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Thyroid Condition |
| ☐ | ☐ | Crossed/Lazy Eyes |
| ☐ | ☐ | Asthma/Allergies |
| ☐ | ☐ | Color Blindness |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | HIV/Hepatitis |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Neuromuscular |
| | ☐ | Blindness |

Other:

_____

_____

_____

Checkoff all that apply....

- ☐ 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/Reflections/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

Are you interested in.....

- ☐ 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
- ☐ Disposable contact lens
- ☐ Bifocal contact lens
- ☐ Myopia control
- ☐ Refractive Surgery
- ☐ Dry Eye therapy

How were you referred to us.....

- ☐ Family Doctor
- ☐ Another Patient
- ☐ _____

Reason for your visit:

☐ Regular check up, or.... _____

Medications you take: _____
(use reverse side if needed) _____

Occupation/School: _____

Employer/Teacher: _____

Family Doctor: _____

Allergies: _____

Hobbies: _____

*We thank you for completing this form*

***Dr. Mark Lukito OD***