ARMESTO
EYE ASSOCIATES
LLC

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**MEDICAL INFORMATION FORM** **DATE: _____**

**NAME: _____ DOB: _____ AGE: _____ SEX: M F**

PLEASE CHECK IF ANY OF THE FOLLOWING APPLY TO YOU AND THE DATE IT FIRST OCCURRED:

| MEDICAL PROBLEM | Y | N | DATE | |
|---|---|---|---|---|
| ALZHEIMER'S | | | | |
| ARTHRITIS | | | | |
| ASTHMA / COPD / BRONCHITIS | | | | |
| BLOOD DISORDERS (TYPE) | | | | |
| BLOOD TRANSFUSION | | | | |
| BOWEL DISORDERS | | | | |
| CANCER (TYPE) | | | | |
| DEPRESSION | | | | |
| DIABETES (TYPE) | | | | |
| HIGH BLOOD PRESSURE | | | | |
| HEAD INJURY | | | | |
| HEART DISEASE | | | | |
| HEPATITIS / JAUNDICE | | | | |
| HIV POSITIVE / AIDS | | | | |
| KIDNEY DISEASE | | | | |
| LOSS OF CONSCIOUSNESS | | | | |
| LUPUS | | | | |
| MIGRAINE HEADACHES | | | | |
| NERVOUS DISORDER | | | | |
| PSORIASIS | | | | |
| RAYNAUD'S DISEASE | | | | |
| RHEUMATIC FEVER | | | | |
| SARCOIDOSIS | | | | |
| SEIZURES | | | | |
| STROKE | | | | |
| SYPHILLIS / GONORRHEA / VD | | | | |
| THYROID DISEASE | | | | |
| TUBERCULOSIS | | | | |

**PLEASE LIST ANY SURGERY (OTHER THAN EYE SURGERY) AND DATES:**

_____
_____
_____
_____
_____
_____
_____

**PLEASE LIST ALL CURRENT MEDICATIONS/DOSE:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**ALLERGIES? PLEASE LIST:**

_____
_____
_____
_____

**WHO IS YOUR PRIMARY CARE DOCTOR?**

_____

**WHO IS YOUR OPTOMETRIST (IF ANY)?**

_____

**OTHER MEDICAL PROBLEMS:**

_____
_____
_____

**OCULAR HISTORY:**

| | N | Y |
|---|---|---|
| Amblyopia / Lazy Eye | [ ] | [ ] |
| Cataract | [ ] | [ ] |
| Corneal Disease | [ ] | [ ] |
| Dry Eye | [ ] | [ ] |
| Glaucoma | [ ] | [ ] |
| Herpes | [ ] | [ ] |
| Macular Degeneration | [ ] | [ ] |
| Retinal Detachment | [ ] | [ ] |
| Other _____ | [ ] | [ ] |

**LIST ANY EYE SURGERY AND DATE(S):**

_____
_____
_____
_____
_____
_____
_____
_____
_____

**INTERNAL USE ONLY**

# MEDICAL REVIEW OF SYSTEMS

Do you currently have any problems in the following areas:

| **CONSTITUTIONAL** | **YES** | **NO** |
|---|---|---|
| Fever | [ ] | [ ] |
| Weight loss or gain | [ ] | [ ] |
| Fatigue | [ ] | [ ] |
| **EYES** | | |
| Loss of vision | [ ] | [ ] |
| Loss of side vision | [ ] | [ ] |
| Distorted vision or halos | [ ] | [ ] |
| Fluctuating vision | [ ] | [ ] |
| Flashes | [ ] | [ ] |
| Floaters | [ ] | [ ] |
| Eye pain or soreness | [ ] | [ ] |
| Light sensitivity | [ ] | [ ] |
| Double vision | [ ] | [ ] |
| Crossing or drifting of eyes | [ ] | [ ] |
| Redness | [ ] | [ ] |
| Discharge | [ ] | [ ] |
| Foreign-body sensation | [ ] | [ ] |
| Sandy or gritty feeling | [ ] | [ ] |
| Dryness | [ ] | [ ] |
| Itching | [ ] | [ ] |
| Burning | [ ] | [ ] |
| Excess tearing/watering | [ ] | [ ] |
| Glare | [ ] | [ ] |
| Styes | [ ] | [ ] |
| Other _____ | | |
| **EARS, NOSE, MOUTH, THROAT** | | |
| Hearing difficulty | [ ] | [ ] |
| Ringing or Vertigo | [ ] | [ ] |
| Sinus congestion | [ ] | [ ] |
| Runny nose | [ ] | [ ] |
| Post-nasal drip | [ ] | [ ] |
| Nosebleeds | [ ] | [ ] |
| Dry throat / mouth | [ ] | [ ] |
| Hoarseness | [ ] | [ ] |
| **RESPIRATORY (LUNGS/BREATHING)** | | |
| Cough | [ ] | [ ] |
| Shortness of breath | [ ] | [ ] |
| Wheezing | [ ] | [ ] |
| **CARDIOVASCULAR** | | |
| Chest pain or palpitations | [ ] | [ ] |
| Other _____ | [ ] | [ ] |

| **GASTROINTESTINAL** | **YES** | **NO** |
|---|---|---|
| Swallowing difficulty | [ ] | [ ] |
| Vomiting / Heartburn | [ ] | [ ] |
| Diarrhea / Constipation | [ ] | [ ] |
| Jaundice | [ ] | [ ] |
| Blood in stools / black stools | [ ] | [ ] |
| **GENITOURINARY** | | |
| Urinary frequency | [ ] | [ ] |
| Urinary pain or blood | [ ] | [ ] |
| **Males –** | | |
| Discharge, lesions, masses | [ ] | [ ] |
| **Females –** | | |
| Currently pregnant | [ ] | [ ] |
| Breast masses or discharge | [ ] | [ ] |
| Vaginal bleeding, discharge | [ ] | [ ] |
| **MUSCULOSKELETAL** | | |
| Joint pain, swelling | [ ] | [ ] |
| Redness | [ ] | [ ] |
| Muscle pain or cramps | [ ] | [ ] |
| **SKIN** | | |
| Rashes or color changes | [ ] | [ ] |
| Itching or dryness | [ ] | [ ] |
| Hair or nail changes | [ ] | [ ] |
| **NEUROLOGICAL** | | |
| Headaches | [ ] | [ ] |
| Numbness or tingling | [ ] | [ ] |
| Weakness or paralysis | [ ] | [ ] |
| Fainting or blackouts | [ ] | [ ] |
| **PSYCHIATRIC** | | |
| Anxiety | [ ] | [ ] |
| Depression | [ ] | [ ] |
| Other _____ | [ ] | [ ] |
| **ENDOCRINE** | | |
| Heat or cold intolerance | [ ] | [ ] |
| Excessive thirst or hunger | [ ] | [ ] |
| **HEMATOLOGICAL / LYMPHATIC / IMMUNOLOGY** | | |
| Easy bruising / bleeding | [ ] | [ ] |
| Blood transfusions | [ ] | [ ] |
| Swollen lymph nodes | [ ] | [ ] |

**FAMILY HISTORY**

Have you or your family members been diagnosed with:

| | | Relative |
|---|---|---|
| Glaucoma | [ ] | _____ |
| Macular Degeneration | [ ] | _____ |
| Diabetes | [ ] | _____ |
| Retinal Detachment | [ ] | _____ |
| Cataracts | [ ] | _____ |
| Amblyopia | [ ] | _____ |
| Strabismus | [ ] | _____ |

Famly History Non-remarkable [ ]

| **SOCIAL HISTORY** | **YES** | **NO** |
|---|---|---|
| Are you pregnant? | [ ] | [ ] |
| Do you smoke? | [ ] | [ ] |
| Do you drink alcohol? | [ ] | [ ] |
| Do you drink coffee? | [ ] | [ ] |
| Do you use IV drugs? | [ ] | [ ] |

I am (circle one)

Married Single Widowed Divorced

**PATIENT / RESPONSIBLE PARTY SIGNATURE:** _____ **DATE:** _____

**DATE REVIEWED:** _____ **PHYSICIAN:** _____ **DATE REVIEWED:** _____ **PHYSICIAN:** _____

**DATE REVIEWED:** _____ **PHYSICIAN:** _____ **DATE REVIEWED:** _____ **PHYSICIAN:** _____