TRI VALLEY OPTOMETRY **MEDICAL HISTORY**

NAME (Label) **DATE**

REVIEW OF SYSTEMS : Do you have a problem with…

EYES	YES	NO		YES	NO
Blindness			Burning or Itching		
Loss of Vision			Sandy or Gritty Feeling		
Distorted Vision			Eye Pain or Soreness		
Blurred Vision			Glare/Light Sensitivity		
Double Vision			Chronic Eye Infections		
Cataracts			Tired Eyes		
Crossed Eyes			Halo around Lights		
Flashes or Floaters			Vision Therapy		
Dry Eyes			Eye Surgery		
Watery Eyes			Eye Injury		
Red Eyes			Retinal Detachment		
Mucous Discharge			Glaucoma		

SYSTEMIC HEALTH	YES	NO		YES	NO
Hay Fever			Medicine Allergies		
Fever			Weight Loss		
Vascular Disease			High Blood Pressure		
Sinus Problems			Dry Throat/ Mouth		
Diabetes			Thyroid Problems		
Stomach Ulcers			Bleeding Problems, Anemia		
Kidney			Bladder		
Skin			Breast		
Arthritis			Muscle/Joint Pain		
Headaches, Migraines			Seizures		
Nervous Disorders			Depression		
Asthma			Shortness of Breath		
Emphysema			Lung Cancer		

PAST, FAMILY AND/OR SOCIAL HISTORY		YES	NO
PAST HISTORY (Illness, Operations, Injuries, Medication, Treatments)			
FAMILY HISTORY (Diseases, Hereditary, Risk Factors, Glaucoma)			
SOCIAL HISTORY Do you now or have you ever used:	Tobacco		
	Alcohol		
	Recreational Drugs		

I understand that it is my responsibility to pay for services and materials provided to me at Tri Valley Optometry.

I understand that my vision insurance and medical insurance (when applicable) will be billed and I authorize payment directly to Tri Valley Optometry. I understand that if my insurance does not pay, then I am responsible for payment.

I agree to pay a $40.00 fee for each missed appointment, when I do not provide 48 (forty-eight) hours notice.

PATIENT SIGNATURE _____

Reviewed by	**Date**	**Reviewed by**	**Date**