# Patient Record

**Please Print:**

Patient Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____

Date of Birth: _____ Age: ___ Occupation _____

Referred by: _____ Family Physician: _____

Age of present glasses? ___ Last eye exam date: _____ From Dr. _____

How would you like to receive future appointment reminders?

☐ Mail ☐ Phone Call ☐ Email ☐ Text

| | YES | NO |
|---|---|---|
| Have you been to the doctors at this office before? | ☐ | ☐ |
| Do you take any medication? If so, please list: _____ | ☐ | ☐ |
| _____ | | |
| ☐ Aspirin regularly ☐ High dose vitamins ☐ Antihistamines ☐ Birth Control | | |
| Are you allergic to any medicine? What? _____ | ☐ | ☐ |
| Do you or any family member have Diabetes? Who? _____ | ☐ | ☐ |
| Do you or any family member have Glaucoma? Who? _____ | ☐ | ☐ |
| Do you or any family member have Cataracts? Who? _____ | ☐ | ☐ |
| Do you or any family member have high blood pressure? Who? _____ | ☐ | ☐ |
| Do you or any family member have thyroid problems? Who? _____ | ☐ | ☐ |
| Do you have frequent headaches? _____ | ☐ | ☐ |
| Does sunlight or bright lights bother you? _____ | ☐ | ☐ |
| Do you ever see double? When? _____ | ☐ | ☐ |
| Do you ever have trouble with night vision? _____ | ☐ | ☐ |
| Have you ever had an eye infection, injury or surgery? _____ | ☐ | ☐ |
| Do you have colour vision problems? _____ | ☐ | ☐ |
| Have you **EVER** worn contact lenses in the past? _____ | ☐ | ☐ |
| Do you **NOW** wear contact lenses? _____ | ☐ | ☐ |

How old are you contacts? _____

How many hours a day do you wear your contacts? _____

Types of lenses worn: ☐ Hard ☐ Gas Permeable ☐ Soft ☐ Extended Wear ☐ Astigmatism

Contact Lens fit by: _____ Date: _____

**PAYMENT EXPECTED ON DAY OF VISIT WE HAVE NO BILLING SYSTEM**

**I have read and understand the Privacy Policy of Dr. TY J. Miller, OD, Inc. X _____**