Bryant Vision Clinic

Patient Intake Form

GENERAL INFORMATION

First, Last, MI

Street Address, City, State, Zip

Phone ( ) Email

Preferred Method of Contact cell phone I email I text I other:

How did you hear about us? Marital Status

Date of Birth

Occupation/Employer

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Primary Member Name

Vision Insurance Member ID #

Primary Medical Insurance

Insurance Member and Group ID #:

Primary Member Date of Birth

OCULAR/ MEDICAL HISTORY

Date of Last Eye Exam

Currently Wear Glasses?	yes	I	no
Currently Wear Contacts?	yes	I	no
Reason for Today's Visit			
Difficulty driving?	day		night

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	self	family
Crossed Eye	self	family
Glaucoma	self	family
LASIK or RK	self	family
Lazy Eye	self	family
Macular Degeneration	self	family
Retinal Detachment	self	family

- Blurry vision near I distance I both
- Burning
- Discharge
- Double Vision
- Dryness
- Excess Tearing / Watering
- Eye Infection
- Eye Pain or Soreness
- Floaters or Spots
- Halos
- Headaches
- Itching
- Light Flashes
- Light Sensitivity
- Redness
- Sandy or Gritty Feeling

Current Medications (prescription, over the counter, and dosage)

Allergies (including medication drug allergies)

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS / HIV	self	family
Allergies	self	family
Arthritis	self	family
Asthma	self	family
Benign Prostatic Hyperplasia	self	family
Blood / Lymph Disorder	self	family
Cancer	self	family
Diabetes	self	family
Gastrointestinal Conditions	self	family

Heart Disease	self	family
High Blood Pressure	self	family
High Cholesterol	self	family
Kidney Disease	self	family
Lupus	self	family
Neurological Conditions	self	family
Psychiatric Disorder	self	family
Seizures	self	family
Skin Conditions	self	family
Stroke	self	family
Thyroid Dysfunction	self	family

Extended Medical History:

Do you smoke?	**yes**	**I**	**no**
Have you ever smoked? **If yes to stroke, last occurrence?**	**yes**	**I**	**no**
Are you pregnant or nursing?	**yes**	**I**	**no**