Robins Eyecare

Health Questionnaire

Name _____ **Date of Birth** _____

Address _____ **Soc Sec #** _____

City, State _____ **E-mail Address** _____

Zip Code _____ **Employer** _____

Phone **Home** _____ **Cell** _____ **Position** _____

Vision Insurance _____ **Work Phone** _____

Whom may we thank for referring you to the office? _____

Date of last eye exam: ____/____/____ **What problem(s) are you having with your eyes?** _____

Do you wear glasses? (circle) Reading Distance Both No Glasses

Do you wear contact lenses? (circle) Soft Rigid Bifocals Disposables No Contacts

If you do not currently wear contact lenses, are you interested in trying them? Yes No **Are you interested in changing your eye color?** Yes No

Does your work involve a computer: Yes No **If so, how many hours per day** _____

Family Physician Name / Address: _____

_____

_____

Date of last physical examination: _____

Please list all medications and supplements you currently take and any medical conditions for us to be aware of:

_____

_____

_____

_____

Thank you for taking time to complete the health questionnaire. All information will remain confidential.