James F. Slyman, M.D.
Thomas A. Hawkins, M.D.

DAVIDSON EYE ASSOCIATES, P.A.

Today's Date_____

Chart# _____

HEALTH QUESTIONNAIRE

PLEASE PRINT

Name _____ Age_____

How did you learn about our practice? (Check all that apply)

____ Doctor ____ Website
____ TV ____ Signage
____ Radio ____ Mailer
____ Newspaper
____ Friend/Family
____ Internet
____ Other_____

1. Have you been hospitalized and/or had any surgeries (including out patient) in the past? If yes, please list reasons and approximate dates. Yes _____ No _____

REASON FOR HOSPITALIZATION AND/OR SURGERIES	DATE
(For example) Gallbladder Surgery	

2. Check if you have any allergies to the following:

Medicine ❑ Tape ❑
Food ❑ Latex ❑
Others ❑

Please list_____

3. Have you ever been diagnosed with MRSA? (please circle) Yes / No

4. Are you taking any medicines (including any drops, contraceptives, aspirin products, cold remedies, vitamins etc.)? If you have a list, we will make a copy for you.
Yes _____ No _____ If yes, list drugs and dosages.

MEDICINE	DOSE	MEDICINE	DOSE

Please circle the correct response:

4. Do you smoke? Yes / No
Living Arrangement: By Myself / With Someone / Rest Home / Retirement Home / Nursing Home
Do you drive? Yes / No
Alcohol? Yes / No / Occasionally
Any weight change during the past 1 year: Gain / Loss / No Change

5. Do the following diseases run in your family (parents, grandparents, brothers & sisters).

Cancer	Yes / No	Migraine	Yes / No	Macular Degeneration	Yes / No	Farsightedness	Yes / No
Stroke	Yes / No	Diabetes	Yes / No	Glaucoma	Yes / No	Crossed Eyes	Yes / No
High Blood Pressure	Yes / No	Arthritis	Yes / No	Cataracts	Yes / No		
Heart Attack	Yes / No	Blindness	Yes / No	Nearsightedness	Yes / No		

6. Do you have or have had the following illnesses.

Glaucoma	Yes / No	Heart Attack	Yes / No	Ulcer	Yes / No	Seizure	Yes / No
Cataracts	Yes / No	Heart Failure	Yes / No	Kidney Stones	Yes / No	Migraine Headaches	Yes / No
Blindness	Yes / No	Asthma	Yes / No	Kidney Infection	Yes / No	Cancer	Yes / No
Crossed Eyes	Yes / No	Bronchitis	Yes / No	Diabetes	Yes / No	Other	Yes / No
Emphysema	Yes / No	High Blood Pressure	Yes / No	Thyroid	Yes / No	Explain _____	
Hepatitis	Yes / No	Stroke	Yes / No	Anemia	Yes / No	_____	
Angina	Yes / No	Cirrhosis	Yes / No				