Valley Eye Surgical Center

Pre-operative Health Questionnaire

Patient Name_____ Your Phone #_____
Date of Birth_____
Your Surgeon's Name_____

Have you ever had:

Y__N__ Heart Condition(s) including; Heart attack, Angina, Bypass surgery?
Y__N__ History of Asthma, Breathing Problems, Tuberculosis, COPD, Persistent Cough, Sleep Apnea?
Y__N__ History of Diabetes? ___Insulin Dependant ___Non-Insulin Dependant
Y__N__ History of Stroke, Seizures, Convulsions, Restless Leg Syndrome?
Y__N__ History of Jaundice, Hepatitis, Liver Problems?
Y__N__ (HIV) Human Immunodeficiency Virus, Autoimmune Disease, Chemotherapy?
Y__N__ History of Kidney Disease? Dialysis Y__N__ What days do you go for dialysis?_____
Y__N__ History of Cancer Surgery? Where on your body was the Cancer?_____
Y__N__ Head, Neck or Back Surgery? If Yes, What_____
Y__N__ History of a bad reaction to local or general anesthesia? If yes, please explain_____
_____
Y__N__ History of Malignant Hyperthermia for you or any of your family members?
Y__N__ History of Allergies to Medications? If yes, please explain_____
_____

My Current Height is--_____ **My Current Weight is--_____**

Do you:

Y__N__ Have a pacemaker or internal defibrillator? If Yes, Which device?_____
Y__N__ Have any metal implants in your body? If Yes, Where?_____
Y__N__ Have any prosthetic devices? If Yes, Where?_____
Y__N__ Have Dentures, Caps, Bridges or Loose Teeth?
Y__N__ Wear Contact lenses?
Y__N__ Use a Wheelchair, Walker, Cane

Please List you medications below:

Medication Name	Dosage/Strength

My Emergency Contact Person is:_____
They can be reached at the following phone #_____
My relationship to this person is:_____

**You should expect to receive a phone call from our Surgical Center the day before your scheduled surgery during regular business hours. If you prefer us to call you on an alternate telephone number please list it here_____.

_____ _____
PATIENT SIGNATURE DATE