EYE SURGERY CENTER
OF NORTH DALLAS

HEALTH HISTORY QUESTIONNAIRE

Name: _____ **M / F** Age:____ Wt:____ Ht:_____

Do you wear? *(Circle one)*
Contacts: Y N **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both
012
Allergies to Medications, Foods, Tape, LATEX, etc.: _____
(Please list)
Who will take you home? _____Relationship:_____ Phone#_____

Current Medications (Prescription / Over-the-Counter / Herbal) – *(please attach list if necessary)*

Medication	Dose / Mg	X per day	Medication	Dose / Mg	X per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
If yes, describe_____
Previous Surgeries/dates _____

Medical History *(Check all that apply to you)*

Cardiac
☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Irreg. Heart Beats/A-Fib
☐ Coronary Bypass #___
☐ High Blood Pressure
☐ Pacemaker/AICD

Lungs
☐ Asthma/Use Inhalers
☐ Emphysema
☐ COPD/Use Oxygen at home?
☐ Bronchitis
☐ Allergies
☐ Sleep Apnea/Wear CPAP?
☐ Smoker, # Packs per Day

Thyroid
☐ Hyperthyroid
☐ Hypothyroid

Eyes
☐ Glaucoma ☐ Cataract surgery
☐ Retina surgery

Kidney
☐ Chronic Urinary Tract Inf.
☐ Dialysis, When_____
☐ Voiding at Night #_____

Liver
☐ Hepatitis A,B,or C
☐ Cirrhosis
☐ Reflux
☐ Frequent Heartburn

Diabetics
☐ Oral Meds
☐ Insulin Reg/NPH
☐ Diet Controlled

Central Nervous System
☐ Stroke/TIA's
☐ Seizures/Migraines

Pregnancy Screen
☐ Possibility that you might be pregnant? If yes, please speak with your surgeon

Other
☐ Alcohol Use - How Often_____
☐ Drug Use - Specify_____
☐ Bleeding Disorders
☐ History of Mental Illness
☐ Active Infection (MRSA, TB, etc)
☐ HIV/AIDS
☐ **Take / Have taken FLOMAX**

PATIENT STICKER

Patient / Guardian Signature:_____ **Date:**_____

There have been no changes to the above: _____ _____
Patient Signature Date