BERGEN-PASSAIC
CATARACT SURGERY & LASER CENTER, INC

PRE-OP HEALTH QUESTIONAIRRE

Patient Name: _____ DOB _____

Height _____ Weight_____

Please indicate if you have, have ever had, or do any of the following	**Comments**	**(Clinical Use Only)**
☐ Hypertension ☐ High Cholesterol ☐ Cardiac Dr _____ ☐ Chest Pain ☐ Shortness of Breath ☐ Peripheral Vascular Disease ☐ Heart Attack ☐ Cardiomegaly ☐ Cardiomyopathy ☐ Heart Bypass ☐ Cardiac Stent(s) ☐ Defibrillator or Pacemaker ☐ Abnormal EKG ☐ Abnormal Heart Rhythm / Irregular Beat ☐ Abnormal Stress Test ☐ Abnormal Echocardiogram or Catheterization ☐ Stroke ☐ Seizure ☐ Convulsions		
☐ Asthma or Breathing Problems ☐ Lung Dr _____ ☐ COPD ☐ Bronchitis ☐ Pneumonia ☐ Obstructive Sleep Apnea ☐ Abnormal Chest X-ray ☐ CPAP ☐ Home Oxygen ☐ Severe Coughing, Night Sweats or Fatigue ☐ History of Tuberculosis ☐ Travel outside of the USA ☐ Not Able to Lie Flat		
☐ Blood Thinners ☐ Bleeding Problems / Tendency ☐ Anemia ☐ Jaundice ☐ Hepatitis ☐ Liver Problems ☐ HIV/AIDS ☐ Autoimmune disease ☐ Thyroid ☐ Anxiety Problems ☐ Chronic Back Problems ☐ Glaucoma ☐ Kidney Disease and/or Dialysis Shunt location _____ ☐ Recently been hospitalized ☐ Cancer Type _____ ☐ Breast Surgery ☐ R ☐ L Type:_____ ☐ Other Surgery(s) List _____ ☐ Problems with anesthesia ☐ Personal History ☐ Family History		
☐ Diabetes What was your blood sugar today _____		
☐ Allergies or Reactions to Drugs, Latex, or Foods Please list below _____ _____		
☐ Smoke How much _____/day ☐ Drink Alcohol _____/day ☐ Hearing Aid ☐ Dentures ☐ Caps ☐ Bridges ☐ Loose Teeth		
☐ Take Prescription, Over the Counter or Herbal Medications Please list all medications and dosages below – continue on reverse if necessary Medication / Dosage / Taken Today _____ _____ ☐ _____ _____ ☐ _____ _____ ☐ _____ _____ ☐ ☐		

_____ _____

Patient Signature **Date**