

NORTH IDAHO CATARACT AND LASER CENTER- HEALTH QUESTIONNAIRE

NAME _____ BIRTHDATE _____ HEIGHT _____ WEIGHT _____

Primary Care Physician: _____ Last exam: _____

Heart Specialist: _____ Last exam: _____

Lung Specialist: _____ Last exam: _____

Other Specialists: _____ Last exam(s): _____

| | | | | | | |
|--------------------------------------|-----------|----------|------------|------------|-----------------------------------|----|
| <i>Please circle all that apply:</i> | | | | | Do you have a living will? | |
| Do you wear hearing aids? | Right ear | Left ear | Both ears | | yes | no |
| Do you wear contact lenses? | Right eye | Left eye | Both eyes | | | |
| Do you wear glasses? | Distance | Reading | Bifocals | Trifocals | | |
| Do you use (daily or occasional): | Cane | Walker | Wheelchair | Prosthesis | Other: | |

Please list all of your previous SURGERIES. If recent, please list approximate date.

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Any PROBLEMS with Anesthesia in any of your surgeries? Please describe.

Comments or questions to discuss at your pre-surgery appointment? _____

Please complete both sides.

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MEDICAL ISSUES (current or history of): *Please circle all that apply.*

| | | | | | | | |
|---|-----------------|-----------------|------------------------|-----------------|-----------------|-------------|--------|
| Diabetic? | yes | no | oral meds | insulin | other injection | | |
| Heart problems? | chest pain | heart attack | atrial fib | murmur | pacemaker | stents | bypass |
| Other heart condition- details? | | | | | | | |
| Lung problems? | short of breath | asthma | emphysema | COPD | cancer | sleep apnea | other |
| Have you ever smoked? | current | quit / when? | | | | | |
| Neurological issues? | stroke | seizures | tremors | neuropathy | migraines | other | |
| Psychiatric disorder? | anxiety | depression | PTSD | claustrophobia | other | | |
| Kidney or bladder problems? | UTI | incontinence | dialysis | monitoring labs | | | |
| Gentlemen, prostate problems? | enlarged | cancer | | | | | |
| Have you EVER taken medications or supplements for your prostate? | | | yes | no | | | |
| Ladies, any chance you could be pregnant? | yes | | no | | | | |
| Liver problems? | jaundice | hepatitis A B C | elevated liver enzymes | | | | |
| Any alcohol use? | daily | socially | beer | wine | hard liquor | | |
| Stomach problems? | acid reflux | ulcers | diverticulitis | crohns | IBS | other | |
| Do you have arthritis? | osteoarthritis | rheumatoid | | | | | |
| Do you bruise or bleed easily? | yes | no | Aspirin | Coumadin | Plavix | other | |
| Do you have glaucoma? | Left eye | Right eye | Both eyes | | | | |
| History of steroid treatment? | Prednisone | Cortisone | inhaler | inflammation | pain | other | |

Any other health problems not previously listed? _____

Please complete both sides.

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