EYE ASSOCIATES NORTHWEST

# PREOPERATIVE HEALTH QUESTIONNAIRE

Patient's Name: _____ Date: _____ Today's Blood Pressure: ____ /____

Do you have Advanced Directive? ☐ Yes ☐ No

If yes, you *may* bring a copy for your surgical chart. If no, would you like Advanced Directive paperwork to fill out? ☐ Yes ☐ No

Age: _____ Height: _____ Weight: _____

**Please check Yes or No for every question.**

| **Heart** | **Yes** | **No** |
|---|---|---|
| High blood pressure | ☐ | ☐ |
| Chest tightness or pain, angina | ☐ | ☐ |
| Recent fainting or blackouts | ☐ | ☐ |
| Heart valve disease | ☐ | ☐ |
| Heart valve replacement, if yes, Date ____/____ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| Are you able to walk up a flight of stairs without shortness of breath? Reason _____ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ |
| Irregular heartbeat | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Automatic implanted defibrillator | ☐ | ☐ |
| **Heart attack, if yes, Date __ /__ /____ How many? ___** | ☐ | ☐ |
| Open heart surgery, (CABG) if yes, Date __ /__ /____ How many vessels were repaired? _____ | ☐ | ☐ |
| Angioplasty | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| **Lungs** | **Yes** | **No** |
|---|---|---|
| Asthma, emphysema or wheezing | ☐ | ☐ |
| Sleep apnea | ☐ | ☐ |
| CPAP machine | ☐ | ☐ |
| Oxygen dependent, if yes, _____ liters | ☐ | ☐ |
| Difficulty breathing when lying flat | ☐ | ☐ |

| **Lungs cont.** | **Yes** | **No** |
|---|---|---|
| COPD | ☐ | ☐ |
| TB or positive TB test | ☐ | ☐ |
| Frequent cough | ☐ | ☐ |
| Currently smoke/vape, how much? packs per day _____ | ☐ | ☐ |
| Former smoker, when did you quit? _____years ago | ☐ | ☐ |

| **Kidney/liver/Glands** | **Yes** | **No** |
|---|---|---|
| Serious liver disease/liver failure | ☐ | ☐ |
| Hepatitis currently **or** in the past, if yes, Type _____ Date __ /__ /____ | ☐ | ☐ |
| Diabetes Type _____, if yes, controlled by ☐ insulin ☐ pills ☐ diet | ☐ | ☐ |
| Check blood sugars @home? Last reading _____ date: _____ | ☐ | ☐ |
| Kidney disease/kidney failure | ☐ | ☐ |
| Kidney dialysis If yes, date of last dialysis __ /__ /____ | ☐ | ☐ |
| Thyroid disease | ☐ | ☐ |

| **Brain and Nervous System** | **Yes** | **No** |
|---|---|---|
| Stroke or mini stroke (TIA) | ☐ | ☐ |
| Brain or nerve disorder | ☐ | ☐ |
| Seizure disorder or epilepsy | ☐ | ☐ |
| Parkinson's Disease | ☐ | ☐ |
| Numbness, weakness in arms or legs | ☐ | ☐ |
| Alzheimer's Disease | ☐ | ☐ |
| Developmentally delayed | ☐ | ☐ |

| Muscular/Skeletal System | Yes | No |
|---|---|---|
| Arthritis: ☐ general ☐ rheumatoid | ☐ | ☐ |
| Chronic back pain | ☐ | ☐ |
| Wheelchair dependent | ☐ | ☐ |
| Use a ☐ walker or ☐ cane | ☐ | ☐ |
| Frequent falls | ☐ | ☐ |

| Eyes, Ears, Nose & Throat | Yes | No |
|---|---|---|
| Hard of hearing | ☐ | ☐ |
| Wear a hearing aid: ☐ Right or ☐ Left | ☐ | ☐ |
| Difficulty swallowing | ☐ | ☐ |
| Dizzy spells or vertigo | ☐ | ☐ |

| Urinary | Yes | No |
|---|---|---|
| **Females**: Pregnant? ☐unsure ☐N/A ☐Menopause ☐Hysterectomy | ☐ | ☐ |
| History of enlarged prostate or kidney stones, if yes, what medication? _____ | ☐ | ☐ |

| Stomach and Intestines | Yes | No |
|---|---|---|
| Hiatal hernia | ☐ | ☐ |
| Acid reflux/heartburn | ☐ | ☐ |

| Anesthesia | Yes | No |
|---|---|---|
| I've had a serious problem with an anesthetic _____ | ☐ | ☐ |
| I have a relative who has had a high fever with an anesthetic (malignant hyperthermia) or other serious problem _____ | ☐ | ☐ |

| General | Yes | No |
|---|---|---|
| Clotting or bleeding disorder | ☐ | ☐ |
| HIV positive or AIDS | ☐ | ☐ |
| MRSA positive | ☐ | ☐ |
| Prednisone/steroid use past 6 months | ☐ | ☐ |
| Chemotherapy? if yes, Date __ /__ /____ | ☐ | ☐ |

**Allergies** ☐ **No known allergies**

| | Yes | No |
|---|---|---|
| Penicillin | ☐ | ☐ |
| Sulfa | ☐ | ☐ |
| Latex | ☐ | ☐ |
| Betadine / Iodine soap | ☐ | ☐ |
| Adhesive Tape | ☐ | ☐ |

**Please list all allergies to medications**

**Medications** ☐ **No medications**

Please list all medications, over-the-counter medications, vitamins, minerals, and herbal supplements (list name and dose)

**Major Surgeries or hospitalizations** ☐ **No surgeries**

**(i.e. heart surgery, stents, MI, CABG, lung surgery; hospitalized for major infections, stroke, pneumonia, COVID or other serious surgery or hospitalization)**

| Surgery/hospitalization | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

| Social History | Yes | No |
|---|---|---|
| Consumes Alcohol: frequency _____ | ☐ | ☐ |
| Recreational Drug use: frequency _____ | ☐ | ☐ |
| Currently employed: occupation _____ | ☐ | ☐ |