LAKESHORE EYE SURGERY CENTER
PRE-OPERATIVE HEALTH HISTORY

Surgeon: _____

Date of Surgery: _____

PATIENT NAME: _____
(as is appears on driver's license/state identification)

AGE: _____ DOB: _____

HEIGHT: _____ WEIGHT: _____

MALE ❒ FEMALE ❒

DIFFICULTY WITH ANESTHESIA: NO ❒ YES ❒

ALLERGIES _____

LATEX ALLERGY: NO ❒ YES ❒

DESCRIBE: _____

PREVIOUS SURGERY (PLEASE LIST): _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS/ILLNESSES:

	NO	YES
CANCER? TYPE:		
HIGH BLOOD PRESSURE?		
HIGH CHOLESTEROL?		
ANEURYSM?		
HEART ATTACK?		
SIGNIFICANT HEART PROBLEMS?		
IRREGULAR HEART BEATS?		
DEFIBRILATOR?		
PACEMAKER?		
STENT?		
ANGINA?		
BYPASS SURGERY?		
CONGESTIVE HEART FAILURE?		
HISTORY OF TUBERCULOSIS?		
A RECENT COLD OR FEVER?		
SMOKER?		
SHORTNESS OF BREATH?		
SLEEP APNEA?		
HOME CPAP?		
ASTHMA?		
BRONCHITIS?		
EMPHYSEMA?		
OTHER LUNG DISEASE?		
DO YOU REQUIRE PORTABLE OXYGEN?		
PARKINSONS?		
STROKE OR MINI-STROKES?		

	NO	YES
SEIZURE OR CONVULSION?		
MS – MULTIPLE SCLEROSIS?		
MD – MUSCULAR DYSTROPHY?		
MG – MYASTHENIA GRAVIS?		
LIVER PROBLEMS?		
HEPATITIS?		
JAUNDICE?		
DIABETES?		
INSULIN THERAPY?		
THYROID PROBLEMS?		
KIDNEY PROBLEMS?		
KIDNEY DIALYSIS?		
BLEEDING DISORDER?		
ANEMIA (LOW BLOOD COUNT)?		
HISTORY OF BLOOD TRANSFUSION?		
BRUISE EASILY?		
CURRENT INFECTION?		
BREAKS IN SKIN/SORES/RASH/ETC?		
AUTOIMMUNE DISEASE?		
HIV?		
HIATAL HERNIA?		
GASTRIC REFLUX/GERD?		
BACK PROBLEM?		
HISTORY OF ALCOHOL OR DRUG USE?		
HISTORY OF MENTAL HEALTH ISSUES?		
HISTORY OF PROSTATE MEDICATION USE?		

Additional comments: _____

Signature of person filling out form: _____ **Date:** _____ **Info obtained from:** _____

OFFICE USE ONLY

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **PATIENT MRN:** _____