THE EYE SURGERY CENTER OF NORTHERN CALIFORNIA

Health Assessment and History Form

Patient Name:____ DOB:______________________

Primary Care Physician:____

Located at:____

Phone Number:___________________________ Fax Number:____________________________

Instructions: Please complete the following form and provide information on any past or current medical conditions you may have. ***This is very important to assist your anesthesiologist in determining your best care.***

Do you have back, neck, breathing problems that make it difficult for you to lie flat? € YES € NO

If yes please explain:____

HEAD € NONE (PLEASE MARK ALL THAT APPLY)			
€	STROKES		
€	SEIZURES	MEDICATIONS:	LAST SEIZURE:
€	CLAUSTROPHOBIA, DEPRESSION, ANXIETY, DEMENTIA, ALZHEIMER		
€	OTHER MENTAL ILLNESS	PLEASE DESCRIBE:	
€	JAW PROBLEMS /OR PAIN	PLEASE DESCRIBE:	
€	DENTURES	€ UPPER € LOWER € PARTIALS € BRIDGES	
EYES € NONE (PLEASE MARK ALL THAT APPLY)			
€	CATARACTS	WHICH EYE:	DATE OF SURGERY:
€	GLAUCOMA	WHICH EYE:	DATE OF SURGERY:
€	OTHER EYE PROBLEMS:		
EARS € NONE (PLEASE MARK ALL THAT APPLY)			
€	HEARING AIDS	€ RIGHT € LEFT	
NECK € NONE (PLEASE MARK ALL THAT APPLY)			
€	NECK ISSUES	PLEASE DESCRIBE:	
CARDIAC € NONE (PLEASE MARK ALL THAT APPLY)			
€	HIGH BLOOD PRESSURE		
€	IRREGULAR HEART RYTHM		
€	HEART ATTACK	DATE:	
€	CHEST PAIN	ARE YOU ABLE TO CLIMB A FLIGHT OF STAIRS? SHORTNESS OF BREATH?	
€	SURGERY	DATE:	
€	PACEMAKER	LAST CHECK:	
€	IMPLANTABLE DEFIBRILLATOR	LAST CHECK:	
HEMATOLOGY € NONE (PLEASE MARK ALL THAT APPLY)			
€	CLOTTING PROBLEMS		
€	CURRENTLY USING BLOOD THINNERS?	€ ASPIRIN € COUMADIN / WARFARIN € PLAVIX € PRADAXA	

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€	OTHER PROBLEM AFFECTING THE BLOOD	EXPLAIN:	
PULMONARY € NONE (PLEASE MARK ALL THAT APPLY)			
€	ASTHMA	WHEN DID YOU LAST USE YOUR INHALER?	
€	PNEUMONIA	WHEN:	
€	COPD / EMPHYSEMA / BRONCHITIS		
€	SMOKER	HOW MUCH: HOW LONG: QUIT:	
€	SLEEP APNEA	€ CPAP € BIPAP	
GASTROINTESTINAL € NONE (PLEASE MARK ALL THAT APPLY)			
€	REFLUX / INDEGESTION / HEARTBURN		
€	BOWEL OR INTESTINAL PROBLEMS		
€	LIVER PROBLEMS		
€	HEPATITIS	€ B € C € D € E	
RENAL € NONE (PLEASE MARK ALL THAT APPLY)			
€	DIALYSIS	LAST DIALYZED:	
€	URINARY PROBLEMS	€ PROSTATE € MEDICATION FOR PROSTATE	
€	OTHER KIDNEY PROBLEMS	PLEASE DESCRIBE	
ENDOCRINE € NONE (PLEASE MARK ALL THAT APPLY)			
€	DIABETES	€ TYPE 1	€ TYPE 2
€	THYROID	€ HYPERTHYROIDISM	€ HYPOTHYROIDISM
ORTHOPEDIC € NONE (PLEASE MARK ALL THAT APPLY)			
€	ARTHRITIS		
€	PROSTHESIS OR IMPLANTS		

ARE YOU CURRENTLY BEING TREATED FOR VANCOMYCIN RESISTANT ENTEROCOCCI (VRE) OR METHACILLIN RESISTANT STAPHYLOCOCCYS AUREUS (MRSA) € YES € NO
IF YES, HOW LONG HAVE YOU BEEN ON ANTIBIOTICS?_______________________________________

PAST SURGICAL HISTORY: **€ NONE**

PROCEDURE

FOR STAFF USE ONLY

_______________________________________ REVIEWED BY

__________________ DATE / TIME

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