RETINAL AMBULATORY SURGERY CENTER HEALTH QUESTIONNAIRE

To be completed by the patient and sent to the surgery center with the insurance information. Thank you for your cooperation.

Patient Name:____________________________ Surgeon:___________________________

Have You Ever Had?

Y ___ N ___ [ ] Diabetes, [ ] Non-Insulin Dependent, [ ] Insulin Dependent
Y ___ N ___ Heart Problems / Heart Attack, when___________________________________
Y ___ N ___ Stroke
Y ___ N ___ High Blood Pressure
Y ___ N ___ [ ] Blood Thinners, [ ] Bleeding Tendency
Y ___ N ___ [ ] Breathing Problems, [ ] Asthma, [ ] Tuberculosis, [ ] Sleep Apnea
Y ___ N ___ [ ] Epilepsy, [ ] Convulsions, [ ] Parkinson's, [ ] Dizziness
Y ___ N ___ [ ] Jaundice, [ ] Hepatitis, [ ] Liver Problem
Y ___ N ___ [ ] HIV, [ ] Auto Immune Disease
Y ___ N ___ Kidney Disease or Urinary Tract Infection
Y ___ N ___ Chronic Back Problems
Y ___ N ___ Anxiety Problems
Y ___ N ___ History of Cancer, specify___________________________________
Y ___ N ___ A bad reaction to local or general anesthesia____________________________
Y ___ N ___ Allergic to [ ] Latex, [ ] Betadine, [ ] Seafood
Y ___ N ___ Allergies or Reactions to Drugs? If yes, please list:__________________________
Y ___ N ___ Other medical problems. List past surgeries:_______________________________
Y ___ N ___ [ ] Use a Walker, [ ] Wheelchair
Y ___ N ___ Have [ ] Dentures, [ ] Caps, [ ] Bridges? If yes, check off all that applies.
Y ___ N ___ Wear a Hearing Aid?
Y ___ N ___ Wear Contact Lenses?
Y ___ N ___ Smoke? How much?_____________________________
Y ___ N ___ Drink Alcohol? If yes, how much per day?_____________________________
Y ___ N ___ Do you have an Automatic Internal Defibrillator?
Y ___ N ___ Have you currently or in the past taken Flomax?

MEDICATION	DOSE	FREQUENCY

I, the patient, patient's representative or relative, acknowledge receiving the following information, verbally and in writing, Patient's Rights and Responsibilities, the surgery center's policy on Advance Directives and a disclosure of financial interest in this facility by my physician (if applicable).

Patient/Representative Signature:___________________________________ Date:_______________