TreeView
DAY SURGERY

Patient Health Questionnaire

Emergency Contact Name:		**Emergency Contact Phone:**	
Height:		**Weight:**	

MEDICAL HISTORY	No	Yes
Have you had previous eye surgery, eye injections or laser treatment *(please circle)*		
Do you wear contact lenses, glasses or hearing aids?		
Do you have any Allergies? Please specify:		
Allergies to Iodine, Chlorhexidine, Chlorsig eye ointment, Latex rubber *(please circle)*		
Have you or any of your family had problems with local anaesthetics before? Please specify:		
Shortness of breath at night or on slight exertion?		
Asthma, Emphysema, chronic bronchitis or breathing difficulties *(please circle)*		
Significant physical disabilities? Wheelchair? Can you lie flat and still for ½ hour to 1 hour?		
Stroke (CVA) or mini stroke (TIA)?		
Diabetes? Insulin, tablets, diet *(please circle)*		
High blood pressure (hypertension)		
Do you have Glaucoma?		
Epilepsy / blackouts / fainting / prone to falls?		
Blood thinners? Aspirin, Warfarin, Pradaxa, Clopidogrel, Ticagrelor *(please circle)* If on Warfarin, what is your most recent INR?		
Frequent chest pain / angina or have you had a significant heart attack with heart muscle damage in the last 6 months.		
Any pacemaker, ICD, heart valve, cochlear implant or other prosthesis		
Do you suffer from any infectious diseases (Hepatitis B or C, HIV, MRSA)?		
Liver disease (Hepatitis) – yellowness / jaundice?		
Any transplant (kidney, heart, bone marrow, liver)?		
Kidney problems		
Bleeding problem, bruising, blood clot, DVT or pulmonary embolus?		
Women only: Are you or could you be pregnant?		

Other health conditions:

_____

_____

_____

_____

Please list previous surgeries within the past 5 years:

_____

_____

_____

_____

List of other medications:

_____

_____

_____

_____

SUPPORT, COMMUNICATION AND DISCHARGE	No	Yes
Do you need mobility support or help with walking?		
Do you need an interpreter or communication support?		
Do you have any cultural, spiritual, religious or family needs you would like us to know about?		
Can you arrange transport home following your surgery?		
Can you arrange for support at home following your procedure, if required?		
Do you have an Enduring Power of Attorney for personal care & welfare or a Welfare Guardian?		
If Yes, please specify:		

I confirm the information provided is correct to the best of my knowledge. I will advise the doctor or nurse if anything changes before my procedure.

Patient name: _____

Patient/Guardian signature: _____ **Date:** _____

If not the patient, state relationship to patient: _____

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