

# PRE-OPERATIVE PATIENT SELF ASSESSMENT

(CATARACTS UNDER LOCAL ANAESTHETIC)

To be completed by the Patient and returned to the Surgeon's office as soon as possible.

PAGE 1 of 2

OFFICE USE ONLY:

Name: LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

Male  Female

J #: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

OHIP #: \_\_\_\_\_

If you are **GOING HOME THE SAME DAY AFTER YOUR SURGERY**, you **MUST** have a responsible adult to take you home or your surgery will be cancelled. It is also recommended that you have someone stay with you overnight.

Name of Adult to take you home: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Demographic Information

Patient Name: (Last, First)			Date of Birth (DD-MM-YYYY):	
Phone:	Home:	Work/Cell:	Preferred time of day to contact you:	<input type="checkbox"/> 8:00 am –12:00 pm <input type="checkbox"/> 12:00 pm – 4:00 pm
Preferred Language:	<input type="checkbox"/> English <input type="checkbox"/> Other:		Can we leave you a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Do you have any allergies? (Including medications, foods or environment)

ALLERGY	Reaction	ALLERGY	Reaction

## Are you taking any medications? (List all prescribed and non-prescribed medications, including herbal remedies)

MEDICATION (Dose and Frequency)	MEDICATION (Dose and Frequency)

## Additional medication related information:

For medication dosing, please record your **height** \_\_\_\_\_ **AND weight** \_\_\_\_\_

Have you been taking medication for <b>pain</b> routinely in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take <b>aspirin, blood thinners, or anti-coagulants</b> on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever taken medication for your prostate or medications to help you urinate?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Name & phone number of current pharmacy:

Please list any substances or recreational drug use regularly (type and frequency): \_\_\_\_\_

Do you drink Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", how many drinks per day?
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## Please list all of the surgeries you have had:

Surgery:	Date:	Surgery:	Date:

## Obstructive Sleep Apnea Screening

Do you have sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use CPAP or BiPAP? <span style="margin-left: 100px;">If yes, setting at?</span>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you snore loudly (loud enough to be heard through a closed door)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you often feel tired, fatigued or sleepy during the daytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone observed you stop breathing or choking/ gasping during your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have, or are you being treated for high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Male  Female

J #: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

OHIP #: \_\_\_\_\_

Medical History (check all that apply):	
<b>CARDIOVASCULAR</b>	<b>ENDOCRINE</b>
<input type="checkbox"/> Chest Pain or Angina	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Attack	Age of onset: _____
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Take Insulin
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Pacemaker	<b>MUSCULOSKELETAL</b>
<input type="checkbox"/> Clot in Lungs or Legs	<input type="checkbox"/> Arthritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Joint or Bone Implants (metal/ plastic)
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Back or neck problems
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Rheumatic Fever	Location of pain: _____
<b>RESPIRATORY</b>	<b>NEUROLOGICAL</b>
<input type="checkbox"/> Smoking/ Tobacco Use	<input type="checkbox"/> Head Injury
Number of cigarettes per day: _____	<input type="checkbox"/> Stroke
Number of years smoking: _____	<input type="checkbox"/> Loss of Consciousness
Quit? If so, when? _____	<input type="checkbox"/> Loss of Sensation in Legs or Feet
<input type="checkbox"/> Emphysema or COPD	<input type="checkbox"/> Shooting Pain Down Arms or Legs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures/ Epilepsy
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Recent Cold/Cough (last 2 weeks)	<input type="checkbox"/> Swallowing Difficulty
<input type="checkbox"/> Shortness of Breath (when climbing 1 flight of stairs)	<input type="checkbox"/> Dementia
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Gastrointestinal Bleeding	<b>MENTAL HEALTH</b>
<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Anxiety and/ or Depression
<input type="checkbox"/> Liver Cirrhosis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Ulcers	<b>COMMUNICABLE ILLNESS</b>
<input type="checkbox"/> Frequent Nausea or Vomiting	<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
<input type="checkbox"/> Frequent Heart burn	<input type="checkbox"/> HIV/ AIDS
<input type="checkbox"/> Hiatus Hernia	<b>SENSORY/OTHER</b>
<b>GENITOURINARY</b>	<input type="checkbox"/> Vision Difficulties
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Glasses or Contact Lenses
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hearing Difficulties
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Right <input type="checkbox"/> Left
<b>AIRWAY</b>	<b>FAMILY HISTORY</b>
<input type="checkbox"/> Dentures: <input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/> Caps <input type="checkbox"/> Crowns <input type="checkbox"/> Loose Teeth	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Difficulty Moving Head/Neck/Jaw	<input type="checkbox"/> Adverse Reaction to Anaesthetic: _____
<input type="checkbox"/> History of "Difficult Intubation"	<b>FEMALE PATIENTS ONLY</b>
<b>BODY PIERCINGS</b>	<input type="checkbox"/> Do you think you could be pregnant?
<input type="checkbox"/> Location(s): _____	Date of last menstrual period: _____

Signature of Patient or Guardian:

Date: