THE CATARACT AND LASER CENTER

PRE SURGICAL ASSESSMENT FOR AMBULATORY SURGERY

Patient Name:____________________ DOB:________________Surgery Date:________________

CHECK EACH QUESTION YES OR NO-IF YES, PLEASE EXPLAIN

☐ YES ☐ NO 1. Are you taking any medicine, aspirin, injections, pills or using any eye ointments and eye drops? Please list:______________________________

____

☐ YES ☐ NO 2. Have you ever had or are you being treated for any of the following? (Please circle)

Heart Disease	Convulsions	Asthma
High blood pressure	Kidney disease	Bronchitis
Diabetes	Muscle weakness	Other
Sickle cell anemia	Hepatitis or jaundice	

☐ YES ☐ NO 3. Do you have an implanted defibrillator?

☐ YES ☐ NO 4. Are you allergic to anything? (ie….Latex) If so, what? ____________________

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☐ YES ☐ NO 5. Have you ever had surgery before? If yes, when? Type? ____________________

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☐ YES ☐ NO 6. Have you or any blood relative had a reaction to an anesthetic?________________

Explain:____________________________________

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7. Who will be available to support you for the first 24 hours following surgery? __________

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8. Nearest Relative/Friend: ____________________ Tel. #____________________

Patient/Guardian Signature________________________________