MISERICORDIA Health · Centre
The future of care

PRE-OP ASSESSMENT QUESTIONNAIRE

CATARACT PROGRAM

NAME: _____

DATE OF BIRTH: ____ - ____ - ____
DAY MONTH YEAR

PHIN: _____

HOME PHONE: ____ - ____ - ____

ALTERNATE PHONE: ____ - ____ - ____

CLINIC USE ONLY	No	Yes
Is a pre-op **History and Physical** required? ("yes" response to any question 2-12, or BMI above 40)		

Patient Instructions: Please read each question carefully. Questions 1-12 are in the bolded section, and questions 13-41 follow below. Respond with a "✓" in the appropriate "Yes" or "No" box. For "Yes" to questions 2-41, please provide additional information (such as: date diagnosed, medications, treatments, etc.) in the "describe" section. **Every question MUST be answered.**

		YES	NO			YES	NO
1.	What is your current:			4.	Do you use home oxygen?		
	a) **height**: feet inches			5.	a) Do you use a sleep apnea machine?		
	b) **weight**: ☐ kilos ☐ pounds				b) Have you been diagnosed to have sleep apnea?		
2.	**In the last six (6) months** have you:						
	a) Had any angina or chest pain?			6.	Do you have a pacemaker?		
	b) Had a heart attack?			7.	Do you have a heart defibrillator?		
3.	**In the last six (6) months** have you gone to the emergency or been admitted for:			8.	Do you take insulin?		
				9.	Are you on dialysis?		
	a) Your heart?			10.	Are you hemiplegic or paraplegic?		
	b) Shortness of breath?			11.	Do you get short of breath when you walk 1 city block, or climb 1 flight of stairs?		
	c) A stroke?						
	d) Heart failure?			12.	Do you have trouble lying flat (with 1 pillow) For 30 minutes? ☐ CAN'T BREATHE ☐ BACK PAIN		
	e) Seizures or blackouts?						

		YES	NO	DESCRIBE
13.	Have you ever had an anesthetic?			
14.	Have you or any of your blood relatives ever had a reaction to an anesthetic?			
15.	Please list all allergies or adverse drug reactions you have:			
16.	Have you ever had any of the following:			CHECK "✓" ONLY WHAT APPLIES TO YOU. ☐ Epilepsy (seizures) ☐ Blackouts ☐ Stroke ☐ TIA
17.	Do you have tremors or other nerve conditions that make lying still difficult?			
18.	Do you have episodes of:			☐ Recent memory loss ☐ Dementia
19.	Are you presently being treated for:			CHECK "✓" ONLY WHAT APPLIES TO YOU. ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia
20.	Do you feel anxious is small or confined spaces?			
21.	Do you wear hearing aids?			☐ Right Ear ☐ Left Ear ☐ Both Ears

MISERICORDIA Health · Centre
The future of care

PRE-OP ASSESSMENT QUESTIONNAIRE

CATARACT PROGRAM

NAME: DATE OF BIRTH: PHIN:

		YES	NO	DESCRIBE		
22.	Do you drink alcohol? (beer, wine, or liquor)			How much?	How often?	
23.	Do you use recreational drugs?			How much?	How often?	
				What type?		
24.	Do you smoke or chew tobacco?			How many per day?		
25.	Do you have dentures, loose teeth, or capped teeth?					
26.	Have you ever had a heart attack?					
27.	Do you have a heart murmur or valve problem?					
28.	Have you ever been treated for an irregular heartbeat?					
29.	Do you have high blood pressure?					
30.	Do you have asthma?			☐ Inhaler regularly	☐ Inhaler when needed	☐ Prednisone
31.	Do you have any other lung conditions? Such as:			☐ Bronchitis ☐ Pneumonia	☐ Emphysema ☐ Chronic Cough	☐ Tuberculosis
32.	Do you have diabetes?			☐ Diet	☐ Pills	☐ Insulin
33.	Do you have reflux or heartburn?					
34.	Do you have a kidney condition?			☐ On Dialysis ☐ HEMO ☐ PERITONEAL	Day: Location:	Time:
35.	Please list any other important medical problems you have:					☐ ***NONE***
36.	Please list any major operations you have had: **(attach list if more space needed)**					☐ ***NONE***
37.	Please list all medications you take (prescription and non-prescription); including the dose and times per day: **(attach list if more space needed)**					☐ ***NONE***
	Medication:			Dose:	Times per day:	
	Medication:			Dose:	Times per day:	
	Medication:			Dose:	Times per day:	
	Medication:			Dose:	Times per day:	
38.	Please list any infectious diseases you have (such as Hepatitis, HIV, MRSA, VRE, Tuberculosis):					☐ ***NONE***
39.	Can you put in your own eye drops?					☐ Yes ☐ No
	Do you have family/friend that can help with your eye drops?					☐ Yes ☐ No
40.	Do you have someone to pick you up from the health centre, and stay with you overnight after your surgery?					
	☐ Yes Who?					
	☐ No (explain)					- ***Must discuss with surgeon***
41.	May your healthcare team leave detailed messages about future appointments (including your surgery)					
	a) on your answering machine? ☐ Yes ☐ No			b) with a family member?		☐ Yes ☐ No

Date Completed: ____ - ____ - ____ **Signature:** ☐ Patient ☐ Designate
DD MMM YYYY