Winnipeg Regional Health Authority — Caring for Health | Office régional de la santé de Winnipeg — À l'écoute de notre santé

Misericordia Health Centre — The future of care

CATARACT SURGERY

Pre-Op History and Physical Form

Surgeon ____________________

Surgeon fax 204-992-4006

Eye for Proposed Procedure: ☐ Left ☐ Right ☐ Both

Diagnostic tests are not required for cataract surgery. **DO NOT** order or submit lab test results unless obtained in addressing a deterioration in the patient's condition within the last 6 months. Describe the deterioration in "other" below. Otherwise, indicate pre-existing conditions only.

ANESTHESIA CAUTIONS ☐ negative

Hx of anesthetic reaction: ☐ Self ☐ Relative

Description: ____________________

CARDIOVASCULAR ☐ negative

- ☐ Hypertension
- ☐ CAD/IHD
- ☐ Myocardial Infarction
- ☐ Congestive Heart Failure
- ☐ Angioplasty/Stents
- ☐ CABG
- ☐ Pacemaker
- ☐ Internal Cardiac Defibrillator
- ☐ Arrhythmia
- ☐ Valvular Disease
- ☐ Peripheral Vascular Disease

RESPIRATORY ☐ negative

- ☐ Asthma
- ☐ Chronic cough
- ☐ COPD
- ☐ O_2 dependant
- ☐ Recent RTI
- ☐ Obstructive sleep apnea
- ☐ Smoker: Pack-years ______

EXERCISE/POSITION TOLERANCE

Can climb 1 flight of stairs: ☐ without stopping ☐ with stops

- ☐ Cannot climb 1 flight of stairs
- ☐ Cannot lie flat for length of proposed procedure

RENAL ☐ negative

- ☐ Chronic renal insufficiency
- ☐ Haemodialysis
- ☐ Peritoneal dialysis

ENDOCRINE ☐ negative

- ☐ Diabetes Type ☐ I ☐ II
- ☐ BMI greater than 35
- ☐ Thyroid

HEMAETOLOGIC

☐ Negative

- ☐ Anemia
- ☐ Coagulopathy
- ☐ Thrombocytopenia
- ☐ Sickle Cell positive

MUSCULOSKELETAL

☐ Negative

- ☐ Arthritis
- ☐ Back / neck pain
- ☐ Decreased mobility/ROM

INFECTIOUS

☐ Negative

- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ MRSA/VRE
- ☐ HIV ☐ TB

GASTROINTESTINAL

☐ Negative

- ☐ Esophageal reflux
- ☐ Hiatus hernia
- ☐ Post-op Nausea
- ☐ Cirrhosis

PSYCHIATRIC

☐ Negative

- ☐ Substance abuse
- ☐ Anxiety attacks
- ☐ Depression
- ☐ Phobias
- ☐ Bipolar disorder

NEUROLOGIC

☐ Negative

- ☐ Dementia
- ☐ Headaches
- ☐ Tremors
- ☐ Vertigo
- ☐ CVA/TIA
- ☐ Hearing Loss
- ☐ Seizures

PAST SURGICAL HISTORY (include dates)

☐ neg / if yes, describe or [☐ see attached] ____________________

OTHER (i.e. new symptoms, hospitalizations within last 6 months, cancers, etc.)

☐ neg / if yes, describe or [☐ see attached] ____________________

ALLERGIES ☐ neg / if yes, describe or [☐ see attached] ____________________

MEDICATIONS (incl. anticoagulants) ☐ none / if yes, describe or [☐ see attached] ____________________

PHYSICAL EXAM (if abnormal or irregular: describe in space provided, if normal/regular: mark " N " in space provided)

Height ______ cm Weight ______ kg BMI ______ kg/m² HR ______ BP ____ / ____ RR ______ Sp02 ______

Head and Neck ____________________ Neck Circumference ______ cm

Heart Rhythm ____________________ Heart Sounds ____________________

Chest Air Entry ____________________ Adventitious Sounds ____________________

Abdomen ____________________ Extremities ____________________

_____ / _____ / _____
DD MMM YYYY

____________________ Primary care provider – phone

____________________ Primary care provider – name (print)

____________________ Primary care provider – signature