Laterality _____

Today's date: _____ **TEXAS EYE SURGERY CENTER – PATIENT PRE-OP HEALTH HISTORY**

Patient Name:	**Birthdate:**

Cell #_____ Home #_____ Other #_____

Emergency Contact Name /Relationship and #_____

Circle the ***best*** contact number to call you regarding your ***Exact Arrival Time***. The scheduling department will contact you the day before your surgery with your exact arrival time.

Please complete the following information and bring it with you to your Surgery Consultation appointment.

Please check all that apply			
☐ Height: _____	☐ Lung Problems	☐ Elevated Cholesterol	☐ Cancer: Where_____ _____ _____ Date _____
☐ Weight: _____	**Circle all that apply:** Asthma/COPD/Sleep Apnea/CPAP/BPAP /Shortness of breath	☐ Chest Pain	
☐ Preferred Language _____		☐ Heart attack Date _____	
☐ Cane	☐ Tuberculosis past or present	☐ Heart Stent Date_____	☐ Diabetes: Oral/Diet/Insulin
☐ Walker	☐ Oxygen Use	☐ Irregular heartbeat	☐ Nerve pain in extremities
☐ Wheelchair	☐ Arthritis	☐ Pacemaker	☐ Restless leg (shaking legs when resting)
☐ Scooter	☐ Acid Reflux	☐ Internal Defibrillator	☐ Parkinson's
☐ Hard of Hearing	☐ Stomach	☐ Stroke Date_____	☐ Tremors
☐ Hearing Aid	☐ Colon Issues	☐ Blood clot Date_____	☐ Depression
☐ Wears contacts	☐ Liver/Hepatitis	☐ Unusual Bleeding Tendencies	☐ Anxiety
☐ Smoker: Prior_____ Current _____	☐ Kidney Disease	☐ Seizures Last one_____	☐ Problems with anesthesia
☐ Alcohol Use	☐ Dialysis: Days M T W TH F Sat		☐ Other:
☐ Recreational Drugs	☐ Prostate Issues		
☐ MRSA	☐ Thyroid		
☐ VRE	☐ Hypertension		
☐ HIV			

ALLERGIES List allergies and reactions to medications/food/Latex/environmental. Example: Sulfa/Rash	

SURGERIES List previous surgeries	

KK102218

MEDICATIONS – TURN PAGE OVER ⇨

List of current medications – Prescription and over-the-counter medications

TAKE	Medication Name	Dose	Time(s) Taken	Why do you take it?