Palisades Eye Surgery Center

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Bethesda, MD 29814
(301) 657-8200

☐ E______

Pre-Operative Questionnaire

PLEASE COMPLETE AND BRING WITH YOU TO YOUR PREOP APPOINTMENT

Patient's Name____

Date of Surgery____________________

1. **Have you ever had any anesthesia or operation in your life?** ☐ Yes ☐ No
   If Yes, what and when:____
   ____
   ____
2. **Have you ever had any serious injuries or illness?** ☐ Yes ☐ No
   If Yes, what and when:____
3. **Are you pregnant?** ☐ Yes ☐ No ☐ N/A
4. **Have you or any person in your family ever had any problems with anesthesia in the past?** ☐ Yes ☐ No
5. **Are you allergic to any drugs?** ☐ Yes ☐ No
   If Yes, what and describe reaction:_________________________________
   ____
6. **Are you allergic to Latex?** ☐ Yes ☐ No (If yes, contact Dr. Chu as soon as possible)
7. **What medications are you taking? List name, amount, how often, and the reason for taking medication.** ☐ NO, I DO NOT TAKE ANY MEDICATION

Drug/Amount	How often	Reason

8. **Have you ever had:**

Heart Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Bleeding Problems	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Back Trouble	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mental Illness	☐ Yes ☐ No

If Yes, did you receive any treatment? Describe:
____
____
____

9. **Do you smoke?** ☐ Yes ☐ No **If Yes, for how long?**______ **How much?**_________
10. **Do you use Alcohol?** ☐ Yes ☐ No **If Yes, how much?** ________**how often?**_______
11. **Do you have any dentures, removable or capped teeth?** ☐ Yes ☐ No
12. **Do you have any medical condition that you feel your Anesthesiologist should know about?**____
13. What is your height?____________ Weight?__________

Form completed by_____________ **Date** ________ **Relationship to patient**________