Kensington Health Eye Institute

340 College St
Toronto, Ontario, M5T 3A9

PRE-OPERATIVE PATIENT QUESTIONNAIRE

Patient's Name: ____________________
Surgeon's Name: ____________________
Surgery Date: ____________________

Please complete and submit this health history to your **surgeon's office before** your surgery. The patient name the surgeons' name and the surgery date **must** be written on every page in the spaces provided.

PART A – PATIENT HEALTH HISTORY - PATIENT OR FAMILY TO COMPLETE

Last Name: ______________________________ First Name: ______________________________

Date of Birth: _____/_____/_____ (YYYY MM DD) Age: ________ Height: ________ ☐ feet ☐ cm

Weight: ________ ☐ lbs ☐ kg

Home Phone: ______________________________ Cell Phone: ______________________________

Email: ______________________________

Have you travelled out of the country in the last six months? ☐ Yes ☐ No

What language do you speak/understand? ☐ English ☐ Other (Please specify): ____________________

If you need an interpreter, contact your surgeon's office

Emergency Contact's Name: ____________________ Relationship: ____________________

Emergency Contact's Phone: ____________________

Name of Family Doctor: ____________________ Phone: ____________________

ALLERGIES (IF YOU HAVE A LIST, PLEASE BRING IT TO YOUR APPOINTMENT)

Do you have Allergies and/or intolerances ☐ Yes (List Below) ☐ No ☐ Not Sure

Allergic to:	Reaction:

MEDICATIONS: (BRING ALL YOUR MEDICATIONS IN THEIR ORIGINAL CONTAINERS AND A LIST FROM YOUR PHARMACIST)

MEDICAL HISTORY (SELECT ALL THAT APPLY)

HEART HEALTH

☐ Heart Attack ☐ Heart Murmur ☐ Angina/Chest Pain ☐ Blockages

☐ Stent/Angioplasty ☐ Valve Problems ☐ Irregular Heartbeat ☐ Heart Failure

☐ Peripheral Vascular Disease ☐ Pacemaker or Implantable Defibrillator

☐ Other (Please specify): ______________________________

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Do you have high blood pressure? ☐ Yes ☐ No ☐ Not Sure

Do you feel short of breath when lying flat? ☐ Yes ☐ No

Have you had any heart tests other than ECG in the last 2 years? ☐ Yes ☐ No ☐ Not Sure

Can you do the following at a normal pace without stopping?
Walk 1 block ☐ Yes ☐ No
Climb 1 flight of stairs ☐ Yes ☐ No

Cardiologist's Name: ______________________________ Phone: ______________________________

PREVIOUS HOSPITALIZATIONS

Have you been admitted to a hospital in Canada or abroad in the past 2 years? ☐ Yes ☐ No

LIST ALL SURGERIES YOU HAVE HAD

Procedure	Hospital	Year

ANESTHETIC HISTORY

Have you ever had general anesthesia? ☐ Yes ☐ No

Have you ever had regional anesthesia? (eg. nerve block, epidural or spinal) ☐ Yes ☐ No

Have you been told by a doctor that you have had problems with an anesthetic?
☐ Difficult Intubation ☐ Malignant Hyperthermia ☐ Confusion after surgery

Has anyone in your family ever had any serious problems with an anesthetic? ☐ Yes ☐ No ☐ Not Sure

Do you have any trouble opening your mouth or moving your neck? ☐ Yes ☐ No ☐ Not Sure

MEDICAL HISTORY (SELECT ALL THAT APPLY)

REPIRATORY HEALTH

☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Tuberculosis
☐ Tracheostomy ☐ Other (Please specify): ______________________________

Do you use oxygen at home to help you breathe? ☐ Yes ☐ No ☐ Not Sure
Have you seen a respirologist in the past 2 years? ☐ Yes ☐ No

ENDOCRINE AND METABOLIC HEALTH

Do you have diabetes? ☐ Yes ☐ No Are you on? ☐ Insulin ☐ Diabetic pills ☐ Diet only

Do you have thyroid problems? ☐ Yes ☐ No ☐ Not Sure
Other: ______________________________

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KIDNEY AND BLADDER HEALTH

Do you have kidney disease? ☐ Yes ☐ No ☐ Not Sure

Are you on dialysis? ☐ Yes ☐ No ☐ Not Sure

Have you seen a nephrologist in the past 2 years? ☐ Yes ☐ No ☐ Not Sure

Nephrologist's Name: ______________________________ Phone: ____________________________

BLOOD HEALTH

☐ A diagnosed blood disorder
☐ Hepatitis
☐ Sickle cell trait
☐ Anemia (low blood count)
☐ Sickle cell anemia
☐ A blood clot (in lungs, legs, or elsewhere)
☐ HIV/AIDS
☐ Other (Please specify): ____________________________________

Have you received blood or blood products in the last 3 months? ☐ Yes ☐ No ☐ Not Sure

Haematologist's Name: ____________________________ Phone: ____________________________

NERVE, MUSCLE AND BONE HEALTH

Have you ever been diagnosed with:

☐ A disease that affects your muscles/nerves
☐ Spinal cord problems (e.g. spinal stenosis)
☐ A seizure disorder (e.g. spinal epilepsy)
☐ Fainting spells, vertigo in the past 2 years
☐ Osteoarthritis
☐ A stroke or stroke-like symptoms
☐ Fibromyalgia
☐ Dementia
☐ Neuropathy
☐ Ankylosing spondylitis
☐ A brain aneurysm
☐ Unable to lie flat
☐ Migraines
☐ Alzheimer's Disease
☐ Rheumatoid arthritis
☐ Other (Please specify): ____

MEDICAL HISTORY (SELECT ALL THAT APPLY)

STOMACH AND INTESTINAL HEALTH

☐ Feeding tube
☐ Heartburn/reflux
☐ Hiatus hernia (stomach)
☐ Liver disease
☐ Inflammatory bowel disease
☐ Other: ____

Do you have difficulty eating or swallowing? ☐ Yes ☐ No

Do you have any nausea, vomiting, choking? ☐ Yes ☐ No

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OTHER IMPORTANT MEDICAL INFORMATION

Do you use any street drugs? ☐ Yes ☐ No
If yes, please list: ______________________________ How often? ______________

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much: ______________________________ How often? ______________

Is there a possibility that you could be pregnant? ☐ Yes ☐ No

Have you ever had cancer? ☐ Yes ☐ No
When: ______________________________ Type: ______________

Chemotherapy/Radiation? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how often? ______________

Do you smoke or consume cannabis? ☐ Yes ☐ No If yes, how often? ______________

Have you had problems with your mental health? ☐ Yes ☐ No
If yes, please specify: ______________________________

Do you have any hearing impairments? ☐ Yes ☐ No

Do you have any mobility limitations? ☐ Yes ☐ No

Do you have claustrophobia? ☐ Yes ☐ No

Please tell us about any other illnesses, limitations or concerns we should know about:

____
____
____

Patient Health History Questionnaire completed by:

Print Name	Signature	Relationship to patient	Date