THE EYE HOSPITAL

HEALTH HISTORY QUESTIONNAIRE

Office use only.

SURNAME……..……GIVEN NAME……..……..……

ID NUMBER……..……SEX……..……..

DATE OF BIRTH……PHONE……

Patient Name: _____ DOB: ___/___/____

Address: _____ State: _____ Postcode: _____

Height (cms): _____ Weight (Kgs): _____ Proposed Date of Admission: ____/____/_____

Q	**Medical History** *(If answered yes to any questions please clarify page 2.)*	***Please Circle***
1.	Have you or a family member had a problem with anaesthetic?	Yes No
2.	Are you allergic or sensitive to anything at all? If YES - please list on reverse side.	Yes No
3.	Do you take any blood thinning (anticoagulant) medication? *(Please do not cease medication unless advised by your surgeon)*	Yes No
4.	Do you have **Diabetes**? If Yes are you**:** **Insulin dependent?** YES / NO if yes - Pump YES / NO **Non-Insulin dependent** YES / NO if yes - Tablets / Diet	Yes No
5.	Have you had or are you being treated for **High or low blood pressure**?	Yes No
6.	Have you had or do you have **Asthma / COPD / Emphysema or other lung disease and/or surgery**?	Yes No
7.	Do you have **sleep apnoea** or excessive snoring? If yes, do you use CPAP / BiPAP / VPAP?	Yes No
8.	Do you get short of breath on exertion? If yes, how far can you walk?	Yes No
9.	Have you had **Hepatitis** /liver disease / jaundice/ kidney disease?	Yes No
10.	Have you had or are you being treated for **heart problems** including Chest pain / angina or palpitations?	Yes No
11.	Have you ever had heart surgery, including pacemaker / implantable defibrillator / stents / valve replacement / bypass surgery?	Yes No
12.	Do you suffer from **Epilepsy / fits / blackouts**?	Yes No
13.	Have you had a **Stroke**? If yes, what year?.....	Yes No
14.	Have you ever had persistent anaemia / bleeding or clotting disorder?	Yes No
15.	*Please indicate if you have any of the following by circling:* hearing aid prosthesis joint replacements dentures bridge	Yes No
16.	Do you have glaucoma?	Yes No
17.	Have you had surgery in the last 6 months? If yes, what type of surgery? ……	Yes No
18.	Could you be pregnant?	Yes No
19.	Do you suffer from Gastric Reflux (Heartburn)?	Yes No
20.	Do you have a Lap Band or Gastric Sleeve?	Yes No
21.	Do you have Arthritis?	Yes No
22.	Have you had Rheumatic Fever / jaw or neck stiffness?	Yes No
23.	Have you sought treatment for Mental Health Issues?	Yes No
24.	Have you taken cortisone drugs in the last six months?	Yes No
25.	Do you smoke? If YES amount ……..Per day	Yes No

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26.	Do you drink alcohol? If YES amount ……..…Per day	Yes	No
27.	Do you take any medication, vitamins or supplements? If **YES** please list in section below.	Yes	No
28.	Do you have any difficulties standing unaided?	Yes	No
29.	Have you ever had, or have **MRSA, CRE, VRE?**	Yes	No
30.	Have you had an overnight stay in a hospital or residential care facility outside of Tasmania in the last 12 months? If yes where?	Yes	No
31.	Have you travelled overseas within the last 6 weeks?	Yes	No
32.	Do you have 2 or more first or second degree relatives with cCJD?	Yes	No
33.	Do you have an undiagnosed progressive neurological illness of less than 12 months duration?	Yes	No
34.	Did you receive pituitary growth hormone for infertility or human growth hormone for short stature prior to 1986?	Yes	No
35.	Did you have surgery on your brain or spinal cord that included a dura mater graft prior to 1990?	Yes	No
36.	Have you ever been involved in a 'look-back' for cCJD, or received a 'medical in confidence letter' regarding your risk of cCJD?	Yes	No
37.	Do you have any memory problems?	Yes	No
38.	Do you have a responsible adult to collect you from The Eye Hospital at discharge?	Yes	No
39.	Do you have a responsible adult to remain with you for a minimum of 24 hours after surgery?	Yes	No

Please record details of all medication taken including and vitamins or supplements;

Name of Medication	Dosage

Question Number	**If you answered yes to any questions please clarify**