ST JOSEPH'S HEALTH CENTRE TORONTO

PRE-OPERATIVE PATIENT SELF ASSESSMENT

(CATARACTS UNDER LOCAL ANAESTHETIC)

To be completed by the **Patient** and returned to the Surgeon's office as soon as possible.

OFFICE USE ONLY:
Name: _____ (LAST NAME) _____ (FIRST NAME)
Male ☐ Female ☐
J #: _____
DOB: _____
Address: _____
_____
Telephone: _____
OHIP #: _____

If you are **GOING HOME THE SAME DAY AFTER YOUR SURGERY**, you **MUST** have a responsible adult to take you home or your surgery will be cancelled. It is also recommended that you have someone stay with you overnight.

Name of Adult to take you home: _____ Phone Number: _____

Demographic Information				
Patient Name: (Last, First)			Date of Birth (DD-MM-YYYY):	
Phone:	Home:	Work/Cell:	Preferred time of day to contact you:	☐ 8:00 am –12:00 pm ☐ 12:00 pm – 4:00 pm
Preferred Language:	☐ English ☐ Other:		Can we leave you a message?	☐ Yes ☐ No

Do you have any allergies? (Including medications, foods or environment)			
ALLERGY	Reaction	ALLERGY	Reaction

Are you taking any medications? (List all prescribed and non-prescribed medications, including herbal remedies)	
MEDICATION (Dose and Frequency)	MEDICATION (Dose and Frequency)

Additional medication related information:		
For medication dosing, please record your **height** _____ AND **weight** _____		
Have you been taking medication for **pain** routinely in the last 3 months?	☐ Yes ☐ No	
Do you take **aspirin, blood thinners,** or **anti-coagulants** on a regular basis?	☐ Yes ☐ No	
Have you ever taken medication for your prostate or medications to help you urinate?	☐ Yes ☐ No	
Name & phone number of current pharmacy:		
Please list any substances or recreational drug use regularly (type and frequency):		
Do you drink Alcohol?	☐ Yes ☐ No	If "yes", how many drinks per day?

Please list all of the surgeries you have had:			
Surgery:	Date:	Surgery:	Date:

Obstructive Sleep Apnea Screening	
Do you have sleep apnea?	☐ Yes ☐ No
Do you use CPAP or BiPAP? If yes, setting at?	☐ Yes ☐ No
Do you snore loudly (loud enough to be heard through a closed door)?	☐ Yes ☐ No
Do you often feel tired, fatigued or sleepy during the daytime?	☐ Yes ☐ No
Has anyone observed you stop breathing or choking/ gasping during your sleep?	☐ Yes ☐ No
Do you have, or are you being treated for high blood pressure?	☐ Yes ☐ No

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Medical History (check all that apply):	
CARDIOVASCULAR	**ENDOCRINE**
☐ Chest Pain or Angina	☐ Diabetes
☐ Heart Attack	Age of onset: _____
☐ Heart Failure	☐ Take Insulin
☐ Irregular Heart Beat	☐ Thyroid Disease
☐ Pacemaker	**MUSCULOSKELETAL**
☐ Clot in Lungs or Legs	☐ Arthritis
☐ High Blood Pressure	☐ Joint or Bone Implants (metal/ plastic)
☐ Heart Murmur	☐ Back or neck problems
☐ High Cholesterol	☐ Chronic Pain
☐ Rheumatic Fever	Location of pain: _____
RESPIRATORY	**NEUROLOGICAL**
☐ Smoking/ Tobacco Use	☐ Head Injury
Number of cigarettes per day: _____	☐ Stroke
Number of years smoking: _____	☐ Loss of Consciousness
Quit? If so, when? _____	☐ Loss of Sensation in Legs or Feet
☐ Emphysema or COPD	☐ Shooting Pain Down Arms or Legs
☐ Asthma	☐ Seizures/ Epilepsy
☐ Tuberculosis	☐ Migraines
☐ Recent Cold/Cough (last 2 weeks)	☐ Swallowing Difficulty
☐ Shortness of Breath (when climbing 1 flight of stairs)	☐ Dementia
GASTROINTESTINAL	☐ Alzheimer's Disease
☐ Gastrointestinal Bleeding	**MENTAL HEALTH**
☐ Liver Problems	☐ Anxiety and/ or Depression
☐ Liver Cirrhosis	☐ Other: _____
☐ Ulcers	**COMMUNICABLE ILLNESS**
☐ Frequent Nausea or Vomiting	☐ Hepatitis ☐ A ☐ B ☐ C
☐ Frequent Heart burn	☐ HIV/ AIDS
☐ Hiatus Hernia	**SENSORY/OTHER**
GENITOURINARY	☐ Vision Difficulties
☐ Kidney Problems	☐ Glasses or Contact Lenses
☐ Dialysis	☐ Hearing Difficulties
☐ Prostate Problems	☐ Hearing Aid ☐ Right ☐ Left
AIRWAY	**FAMILY HISTORY**
☐ Dentures: ☐ *Full* ☐ *Partial*	☐ Malignant Hyperthermia
☐ Caps ☐ Crowns ☐ Loose Teeth	☐ Muscular Dystrophy
☐ Difficulty Moving Head/Neck/Jaw	☐ Adverse Reaction to Anaesthetic: _____
☐ History of "Difficult Intubation"	**FEMALE PATIENTS ONLY**
BODY PIERCINGS	☐ Do you think you could be pregnant?
☐ Location(s): _____	Date of last menstrual period: _____

Signature of Patient or Guardian:	Date: