

GLACIER EYE CLINIC, P.C.

Eye Surgery Patient Medical Questionnaire

PATIENT INFORMATION					
Last Name	First Name	Middle	Age	DOB MM/DD/YY	SSN (Social Security #)
Family Physician	Date of Last Visit	Referred By		Today's Date	
MEDICAL HISTORY					
Description	Patient	Family	List All Medications You Are Taking		
DIABETES	Yes No	Yes No			
HIGH BLOOD PRESSURE	Yes No	Yes No			
CONGESTIVE HEART FAILURE	Yes No	Yes No			
CORONARY ARTERY DISEASE	Yes No	Yes No			
ARRHYTHMIA / ARTIFICIAL VALVE	Yes No	Yes No			
STROKE	Yes No	Yes No			
COPD / EMPHYSEMA	Yes No	Yes No			
ASTHMA	Yes No	Yes No			
ANEMIA / BLEEDING	Yes No	Yes No			
EMBOLISM (blood clots)	Yes No	Yes No			
KIDNEY / BLADDER	Yes No	Yes No			
THYROID DISEASE	Yes No	Yes No			
DEPRESSION / ANXIETY	Yes No	Yes No			
CANCER	Yes No	Yes No			
OTHER _____	Yes No	Yes No			
Have you ever or do you take any of the following medicines?					Comments
COUMADIN (warfarin) OR ASPRIN?				Yes No	
FLOMAX HYTRIN UROXATRAL CARDURA?				Yes No	
List ALL Previous Surgeries					
PATIENT REVIEW (for Doctor / Nurse use Only)					
Date	BP	Pulse	Other	Surgery Date	
Symptoms	Stable	Comments			
SHORTNESS OF BREATH	Yes No	Yes No			
COUGH	Yes No	Yes No			
CHEST PAIN	Yes No	Yes No			
Post-Op Care	Allergies				
Surgical Eye	Refractive Error Range	BAT<	Symptoms from Cataract		
Right Left					