NORTH TORONTO
EYE SURGERY CENTRE

PATIENT QUESTIONNAIRE

PLEASE RETURN COMPLETED FORM TO YOUR COUNSELOR PRIOR LEAVING THE CLINIC

Patent label

Age_____ Height_____ Weight _____

Please check mark "yes" or "no"	YES	NO	Please provide details when applicable:
Do you have medication(s) allergy?			
Do you have LATEX allergy?			
Do you wear a hearing aid(s)?			
Do you take diabetes medication(s)?			
Do you take blood pressure medication(s)?			
Do you have chest pain sometimes?			
Have you had a heart attack in the last year?			
Do you have a pacemaker?			
Do you have a heart valve(s) disease?			
Do you have a chronic heart failure?			
Do you have COPD (Asthma, Chronic Bronchitis)?			
Do you use oxygen or a CPAP?			
Do you take medication(s) for enlarged prostate?			
Do you have a kidney disease?			
Do you have a liver disease?			
Can you lie down flat?			
Do you have an epilepsy?			
Do you have tremors?			
Have you had a stroke in the last year?			
Do you take sedatives or anti-anxiety medication(s)?			

Please list all your medications including herbals and vitamins:	Please list your recent (last 2 years) hospital admissions:

_____ _____ _____

Name **Signature** **Date**