We look forward to seeing you at your upcoming Cataract Evaluation. In an effort to ensure your surgery is scheduled at the appropriate location, please take a brief moment to fill out the anesthesia questionnaire below. Our technicians will collect this from you and your surgeon will review your answers.

Eyesight Uncompromising Care

ANESTHESIA QUESTIONNAIRE

REQUIRED FOR ALL SURGERY PATIENTS

Name Date:

1.	What is your height? What is your most recent weight?	_____ft _____	_____in lbs	
2.	Have you had any cardiac event within the last 3 months (including heart attack/MI, cardiac stent placement, or cardiac bypass surgery)? If yes, date of cardiac event:	☐ Yes	☐ No	
3.	Have you had a stroke or TIA (mini-stroke) in the last 3 months? If yes, date of stroke or TIA (mini-stroke):	☐ Yes	☐ No	
4.	Have you had a seizure in the last 3 months? If yes, date of seizure?	☐ Yes	☐ No	
5.	Do you require continuous oxygen therapy for any breathing disorder (for example COPD, emphysema, pulmonary fibrosis)?	☐ Yes	☐ No	
6.	Are you currently on any form of dialysis?	☐ Yes	☐ No	
7.	Are you currently undergoing medical workup for chest pain, shortness of breath, abnormal heart rhythm, heart valve conditions, seizures, strokes/TIA(mini-strokes), or a clotting disorder?	☐ Yes	☐ No	
8.	Do you have difficulty with shortness of breath or weakness doing everyday activities (such as walking, cleaning, showering, etc?)	☐ Yes	☐ No	
9.	Have you been to a cardiologist in the last 3 years? If yes, for what reason?	☐ Yes	☐ No	
10.	Have you been hospitalized or evaluated in the ER for any reason within the last month? If yes, then where?	☐ Yes	☐ No	
11.	Are you currently receiving radiation or chemotherapy for metastatic cancer?	☐ Yes	☐ No	
12.	Have you had an allergic or adverse reactions to the medications Versed (midazolam), Propofol, or opioid pain medications? If yes, what medications? _____ What was the reaction you had? _____	☐ Yes	☐ No	
13.	Have you ever been told that you are a difficult intubation or that a medical provider had difficulty placing a breathing tube?	☐ Yes	☐ No	
14.	Do you have any of the following: ☐ Implantable Defibrillator ☐ Implantable Pacemaker ☐ Combined Defib/Pacemaker	☐ Yes	☐ No ☐ None	
15.	Do you take Ozempic or Wegovy?	☐ Yes	☐ No	

THANK YOU!

Please give this form to the technician or the doctor during your appointment.