

**PRE-OPERATIVE
ADMISSION HISTORY**

Allergies: _____

Height: _____ Weight: _____ Scheduled Procedure: _____

Alcohol Use: Y / N How Often? _____ Tobacco Use: Y / N How Often? _____

List of Past Surgeries: _____

Past Medical History: (Please check applicable boxes)

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Problems
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Murmur
<input type="checkbox"/> Other: _____
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> A-Fib
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Defibrillator
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Breathing Problems
<input type="checkbox"/> Asthma
<input type="checkbox"/> COPD
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> CPAP
<input type="checkbox"/> Home Oxygen ___ liters
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Glaucoma
<input type="checkbox"/> Stroke
<input type="checkbox"/> Seizure
<input type="checkbox"/> Neuro issues
<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> MS
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cancer
Site: _____
<input type="checkbox"/> Infectious Disease
<input type="checkbox"/> HIV
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> TB
<input type="checkbox"/> MRSA
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Kidney Disease/Issue
Type: _____
<input type="checkbox"/> Liver Disease/Issue
Type: _____ | <input type="checkbox"/> Problems with Anesthesia
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> High Fever
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> Bleeding or Clotting Issue
Type: _____
<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression

Anything else in your medical or surgical history we should know about?

_____ |
|---|--|---|

INSTRUCTIONS:

For procedures requiring anesthesia:

- No eating or drinking after midnight; no gum, no mints, and no coffee.
- You can take your morning medications with a sip of water but nothing more. If you are diabetic, please DO NOT take your diabetes medications.
- Wear warm, comfortable clothes. You will remain in your clothes and shoes for the procedure. You can wear glasses but no contacts. FOR WOMEN: No eye makeup, and no heavy jewelry
- Make sure to bring your insurance card and photo ID, but leave your valuables at home
- If you're going to be receiving anesthesia that day, you will need to have a driver here responsible for you. That person needs to be over the age of 18, and they have to remain here the entire time. They cannot drop you off and leave you.

For laser procedures (capsulotomy, iridotomy, SLT) or local procedures that do not require anesthesia:

- Laser and local procedures do not require anesthesia so there are no restrictions on eating, drinking, or taking medications.
- Make sure to bring your insurance card and photo ID
- If your eye is to be dilated, bring a pair of sunglasses. You are permitted to drive home at your own discretion. If you are uncomfortable driving with a dilated eye, it is recommended to have someone drive you home.

Please notify a nurse if you have had any of the following:

- Recent travel outside the United States within the last 30 days
- Fever of greater than 101.5 °F within the past 24 hours