Total Eye Care
Cataract Medical History Questionnaire

1. Do you have a history of heart attack, stroke, stent, bypass or surgery on an artery in the head, neck, heart or legs? YES / NO

   If yes, explain: _____

2. Do you have any pain or discomfort in your chest? YES / NO

   If yes, explain: _____

3. Do you have a history of Heart Failure? YES / NO

   If yes, explain: _____

4. Are you troubled by shortness of breath when: walking on the level, up a slight hill, or at night? YES / NO
   If yes, explain: _____

5. Do you currently have a cold, bronchitis, or other repertory infection? YES / NO

   If yes, explain: _____

6. Do you have a cough, shortness of breath, or wheezing? YES / NO

   If yes, explain: _____

7. Do you sometimes get pains in the calves of your legs when you walk? YES / NO

   If yes, explain: _____

8. Do you or anyone in your family have previous history of blood clots? YES / NO

   If yes, explain: _____

9. Do you or does anyone in your family have a serious bleeding problem such as prolonged bleeding following surgeries or cuts? YES / NO

   If yes, explain: _____

continue on back ➔

10. Have you ever had problems with anemia or been told to take iron pills? YES / NO

    If yes, explain: _____

11. Have you had any abnormal blood loss such as black, tarry, or bloody stools, or abnormal vaginal bleeding? YES / NO

    If yes, explain: _____

12. Have you ever had a blood transfusion? YES / NO

    If yes, explain: _____

13. Have you or any of your relatives ever had problems with anesthesia? YES / NO

    If yes, explain: _____

14. Do you have sleep apnea, excessive snoring or daytime drowsiness? YES / NO

    If yes, explain: _____

15. Do you have any prosthetic heart valves? YES / NO

    If yes, explain: _____

16. Do you have an prosthetic joints? YES / NO

    If yes, explain: _____

17. Are you Diabetic? YES / NO

    If yes, list medications: _____

continue on back ➔

continue on back ➔