COQUITLAM CATARACT CENTER

PATIENT HEALTH HISTORY QUESTIONAIRE

PATIENT TO COMPLETE

PATIENT SURNAME (legal) FIRST NAME (legal) Other names	DOB(d/m/yyyy)	CARE CARD #
RESIDENTIAL PHONE BUSINESS PHONE EXT. CELL PHONE	SURGEON / PHYSICIAN	
INTERPRETER REQUIRED? If yes, please specify name and phone#	HEIGHT (cm) WEIGHT (kg)	

What is the reason you are seeking treatment? _____

Do you have any allergies? (Including latex) If yes please list. _____

_____

Have you <u>ever had</u> any of these health issues? (Check appropriate boxes)

- ☐ Heart attack Date:_____
- ☐ Heart murmur
- ☐ Fast or irregular heart beats
- ☐ Heart burn/acid reflux
- ☐ High blood pressure
- ☐ Stroke Date:_____
- ☐ Mental or nervous disorders
- ☐ Genetic/neurological problems
- ☐ Emphysema/breathing problems
- ☐ Asthma/hay fever
- ☐ Rheumatic fever
- ☐ Blood clotting disorder
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Hepatitis/jaundice
- ☐ High cholesterol
- ☐ Arthritis
- ☐ Migraines
- ☐ Glaucoma
- ☐ Sleep apnea
- ☐ Do you have a CPAP machine
- ☐ Pacemaker
- ☐ Thyroid problems
- ☐ Cancer
- ☐ Epilepsy/seizures
- ☐ Back/neck problems

Do you <u>presently</u> suffer from any of the following? (Check appropriate boxes)

- ☐ Chest pains
- ☐ Confusion
- ☐ Nose bleeds
- ☐ Muscle cramps/weakness
- ☐ Headaches
- ☐ Swollen ankles
- ☐ Dizzy spells
- ☐ Anxiety or depression
- ☐ Shortness of breath
- ☐ Memory lapses
- ☐ Vision problems
- ☐ Skin infection or lesions

Yes	No	
☐	☐	Have your or any other member of your family ever had a problem with an anesthetic? If yes, please describe. _____
☐	☐	Do you have an infectious disease? If yes, please specify. _____
☐	☐	Do you have diabetes? If yes, what do you take? _____
☐	☐	Are you pregnant? If yes, how many weeks? _____
☐	☐	Were you (the patient) born prematurely? ____ weeks.
☐	☐	Do you wear contact lenses?
☐	☐	Do you wear hearing aids?
☐	☐	Do you have loose, broken, chipped or capped teeth?
☐	☐	Do you have braces?
☐	☐	Do you have bridges? Permanent ___ Removeable ___
☐	☐	Do you have dentures?
☐	☐	Do you smoke? If yes, how much in a typical day? _____
☐	☐	Do you take drugs? (other than prescribed by a physician) If yes, list _____

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PATIENT HEALTH HISTORY QUESTIONAIRE (Cont'd)

PATIENT SURNAME (legal) FIRST NAME (legal) Other names	DOB(d/m/yyyy)	CARE CARD #

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Have you ever had a referral to a cardiologist (heart specialist) if yes, who _____
How much alcohol do you drink in a typical day? _____
Have you had any operations in your life? If so, please list_____
_____
Have you or anyone in your household been diagnosed with an antibiotic-resistant organism (ARO) such as MRSA or VRE? _____
Have you ever received healthcare in a facility outside of Canada in the last 12 months? _____
Have you been admitted to, or spent more than 12 continuous hours as a patient in any health care facility in the last 12 months? _____
Have you ever had surgery on your brain or spinal cord? _____
Have you a history of Creutzfeldt-Jacob Disease (CJD)? _____
Have you ever received growth hormone or gonadotrophin treatment? _____

*****PLEASE ATTACH A LIST or write below YOUR MEDICATIONS – INCLUDING PRESCRIPTIONS, OVER-THECOUNTER AND HERBAL REMEDIES (please include names and dosages of medication if possible)*****

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT SIGNATURE: _____
DATE (d/m/yyyy): _____

Pre Admission Office Use Only
ASA Class _____
IPC Precautions _____

COQUITLAM CATARACT CENTRE

Main Office | #101 - 2764 Barnet Hwy. V3B 1B9 | T 604.942.1642 | F 604.942.1692

Name _____
Height _____ Weight _____
Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2

COQUITLAM CATARACT CENTRE
SURGERY CONSENT FORM

Name: _____ PHN:_____

Physician: Dr. Michael Butler

Procedure: Refractive Lens Surgery

I consent to the above listed examination, procedures, or treatments. I further agree that the physician listed above my at his/her discretion, make use of any assistance of other doctors and medical staff. It is understood that the physicians may perform other necessary or advisable procedures when in their judgement, medical emergencies or unforeseen circumstances arise.

I confirm that the nature and anticipated effect of such treatment including the significant risks and alternatives available have been explained to me by the physician and I am satisfied with this information.

I also consent to the administration of anesthetics and drugs as may be considered necessary or advisable by the anesthetist.

I authorize the clinic or it's agents to dispose of any removed foreign bodies, tissue or amputated members of my body as a result to the procedure in a manner deemed proper by the clinic.

I understand that for educational purposes there may be health professional students or representatives in attendance and that photographs or videos of the operation site may be done.

_____ _____
Date Signature of Patient

_____ _____
Witness Name (please print) Witness Signature

Declaration of Interpreter, if applicable:

This document was interpreted by me to the patient (and/or the person legally authorized to consent for the patient) who acknowledged in my presence that he/she understood the explanation to the procedure listed below.

_____ _____
Interpreter Name Interpreter Signature

_____
Date

To be completed when person is incapable of consent

_____ _____
Print Name of Person Legally Authorized to Consent for the Patient & Relationship

Signature of Person Legally Authorized to Consent for the Patient & Relationship

_____ _____
If no Legal Authority, Name of Other Person and Relationship

Signature of Other Person Consulted