U SURGICAL CENTRE

Pre- Surgery
Medical History & Physical
for Cataract Surgery

Patient Name: _____ Date: _____

Doctor's Name (Please Print): _____

Allergies: ☐ N /A ☐ Latex ☐ Medication

History of Present Illness	**Past Surgeries**

Past Medical History (include date of inset)	**Medications (prescription & over the counter)** Name	Dose	Frequency
☐ Cancer			
☐ Cardiac			
☐ Malignant Hyperthermia			
☐ Mitral Valve Prolapse			
☐ Hypertension			
☐ Respiratory			
☐ Kidney			
☐ Sleep Apnea			
☐ Diabetes			
☐ Morbid Obesity			
☐ Stroke/ CVA			
☐ Pacemaker			
☐ Seizures	**Specific Abnormalities**		
☐ Hepatitis	Lab _____		
☐ Alpha-1 Block used (past or present) (eg. Flomax, Hytrin) _____	ECG _____		
	Other _____		
☐ Other			

☐ Fit for Surgery

Physical Exam

B/P _____/_____ P _____ Weight _____ kg Height_____cm

	Normal	Abnormal	
General	☐	☐	_____
Head & Neck	☐	☐	_____
Lungs	☐	☐	_____
Heart	☐	☐	_____
Abdomen	☐	☐	_____

Doctor's Signature _____ **Phone Number / Stamp** _____