Pre-op Health History

****Please complete prior to visit at Furlong Vision Correction, call with any questions prior****

Name: Last _____ First_____ Date of Birth _____

Today's Date _____

Age: _____ Sex: M or F Height _____ Weight _____ Surgeon: FURLONG / SANE (circle one)

Primary Care Physician: _____ Phone: _____ Last EKG _____ Last H&P _____

Y	N	#	Do you or have you ever had: Comments
		1	Allergies? List all □including latex, shellfish/iodine, adhesive tape and medications.
		2	Heart problems (heart attack, pacemaker, valve problems, chest pain)?
		3	High blood pressure?
		4	Breathing problems? (Emphysema, asthma or shortness of breath)?
		5	Have you had a recent positive TB test or have a history of TB?
		6	Diabetes? (high blood sugar)?
		7	Kidney problems?
		8	Hepatitis or jaundice?
		9	Seizures, weakness, blackout spells, migraines?
		10	Depression, anxiety attacks, psychiatric conditions?
		11	Bleeding or clotting problems?
		12	Any other MAJOR ILLNESSES (e.g. Cancer, Lupus)?
		13	Any MAJOR SURGERIES or OPERATIONS?
		14	Do you take any medications, vitamins, herbal preparations or diet pills? Please list.
		15	Any reactions to a local or general anesthetic or any family history of such reactions?
		16	Is there any possibility you may be pregnant? If applicable, last menstrual period _____
		17 18 19	Do you smoke: _____ packs/day Do you have dentures_____ Caps_____Loose Teeth?_____ Use alcohol? _____/day or Hearing Aid? _____ Contact lenses? _____ Use recreational drugs: _____ Mobility problems?_____Claustrophobia? Y N
		20	Do you have sleep apnea Y N Do you use a CPAP machine while sleeping? Y N

Please answer all questions above. If you answer yes to any of them, please explain in the comment section above.

Furlong Vision Physician Signature: _____ Date _____