

**PRE-ADMISSION QUESTIONNAIRE FOR DAYTON EYE SURGERY  
CENTER**

**Please complete and return this form to [patdesc@daytoneyes.com](mailto:patdesc@daytoneyes.com) or by fax at  
(937) 431-9532**

Patient Name: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

Name of Cardiologist (if applicable): \_\_\_\_\_

Telephone: \_\_\_\_\_

Have you been seen for your pre-operative physical?  Yes  No

If no, when are you scheduled? \_\_\_\_\_ Where? \_\_\_\_\_

\*Note: A pre-operative physical is needed at least 2 weeks prior to surgery date.

\*\*If you are having the physical performed by your primary care physician, please print a copy of the history and physical form to take with you to the appointment.

Any history or exposure to bedbugs?  Yes  No

If yes, please list the date of last sight or exposure. \_\_\_\_\_

Have you or anyone you live with had any COVID Symptoms in the previous 14 days?

Yes  No

If yes, please indicate the date of the last symptom(s). \_\_\_\_\_

Do you or family members have a history of adverse reaction to anesthesia?  Yes  No

If yes, please describe what symptoms and who experienced them.

\_\_\_\_\_

Do you or family members have a history of Malignant Hyperthermia?  Yes  No

If yes, please describe what symptoms and who experienced them.

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List any previous surgeries (it is not necessary to list dates unless the surgery has been in the last 6 months). \_\_\_\_\_

Surgeries continued.

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Cardiac History

Do you have any history of heart problems? \_\_\_\_\_

Any heart surgery or procedures? Stents, CABG, Angioplasty?  Yes  No

Any history of Hypertension/High Blood Pressure?  Yes  No

History of congestive heart failure?  Yes  No

Any history of chest pain or angina?  Yes  No

Heart Attack?  Yes  No

Irregular heartbeat?  Yes  No

Do you have a defibrillator/pacemaker?  Yes  No

Do you have a history of high cholesterol?  Yes  No

Are you taking anticoagulants/blood thinners?  Yes  No

If yes, your most recent INR. \_\_\_\_\_

Pulmonary History

Do you have any history of breathing problems?  Yes  No

Do you experience shortness of breath/COPD?  Yes  No

Asthma?  Yes  No

Have you been diagnosed with sleep apnea?  Yes  No

Do you use oxygen at home or use a CPAP at night when you sleep?  Yes  No

If on oxygen, do you have an order for portable oxygen?  Yes  No If yes, you will need to bring your portable oxygen tank with you for the ride home.

Positioning

Will you have trouble laying flat for surgery?  Yes  No

Breathing difficulties?  Yes  No

Musculoskeletal?  Yes  No

Vertigo?  Yes  No

Endocrinology

Do you have diabetes?  Yes  No

Type 1  Type 2

Do you take medications for diabetes or weight loss?  Yes  No

Name and Dosage: \_\_\_\_\_

What is your usual glucose/A1C? \_\_\_\_\_

Digestion

Do you have a history of digestive problems?  Yes  No

Acid reflux?  Yes  No

Hiatal Hernia?  Yes  No

Crohn's disease?  Yes  No

Ulcerative colitis?  Yes  No

Gastroesophageal Reflux Disease (GERD)?  Yes  No

Nephrology/Hepatology

Do you have any history of kidney or liver disease?  Yes  No

Kidney?  Yes  No

Are you on dialysis?  Yes  No

Liver disease?  Yes  No

Do you have a thyroid condition? If yes, Hypo or Hyper  Yes  No

Hypothyroidism  Yes  No

Hyperthyroidism  Yes  No

### Hematology

Do you have a history of bleeding problems or blood clots?  Yes  No

Do you have anemia?  Yes  No

Have you ever had a blood clot (DVT)?  Yes  No

Sickle Cell Anemia?  Yes  No

Have you ever been diagnosed with HIV, AIDS, or Hepatitis?  Yes  No

Do you currently have any open wounds or active infections?  Yes  No

Have you had a history of MRSA in the past 12 months?  Yes  No

Are you currently taking any antibiotics for signs/symptoms of infection?  Yes  No

Do you have or have you ever had cancer?  Yes  No

Are you currently receiving Chemo or Radiation treatment?  Yes  No

### Neurologic

Have you ever had a stroke/TIA/Seizures/Tremors?  Yes  No

Restless Leg Syndrome?  Yes  No

Migraines?  Yes  No

Memory loss/Dementia?  Yes  No

If yes, willing to follow commands/cooperative?  Yes  No

Do you have a history of mood disorder, anxiety, or depression?  Yes  No

Depression?  Yes  No

Anxiety?  Yes  No

Is the patient blind?  Yes  No

Right  Yes  No

Left  Yes  No

Both  Yes  No

Do you have arthritis?  Yes  No

Do you use any assisting devices?  Yes  No

Cane?  Yes  No

Walker?  Yes  No

Wheelchair?  Yes  No

Hearing Aids?  Yes  No

Other?  Yes  No \_\_\_\_\_

Could you be pregnant?  Yes  No

Are there any other medical conditions or concerns that we should be aware of?

Yes  No

Allergies

Do you have any drug allergies?  Yes  No

Please list along with the reaction. \_\_\_\_\_

Non drug allergies?  Yes  No

Please list along with the reaction. \_\_\_\_\_

Are there any barriers to learning? (language, vision, or hearing)  Yes  No

Will there be a need for interpretation services?  Yes  No

Do you have a hearing impairment or use of hearing aids?  Yes  No