Baptist Eye Surgery Center
SUNRISE
BAPTIST HEALTH SOUTH FLORIDA

3737 N. Pine Island Road
Sunrise, FL 33351
Phone: 954-572-5888
Fax: 954-634-1634

PATIENT HISTORY QUESTIONNAIRE

Date of Surgery: _____

Name: _____ Age: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

Primary Medical Doctor or Internist: _____ Doctor's Tel. #: _____

Please answer the below questions:	Yes	No	If Yes, please explain.
Have you been hospitalized within 30 days?	☐	☐	
Have you ever had a MRSA infection?	☐	☐	
Do you reside in a nursing home or Assisted Living Facility?	☐	☐	
Have you ever had a reaction to latex?	☐	☐	
Have you ever had kidney problems, failure or are you on dialysis?	☐	☐	
Do you have a pacemaker? If so, please bring card with you on day of surgery.	☐	☐	
Do you have a defibrillator? If so, please bring card with you on day of surgery.	☐	☐	
Have you ever been treated for cancer with chemotherapy or radiation?	☐	☐	
Have you ever had or been treated for heart problems? (i.e. Heart Attack, Chest Pain, High Blood Pressure, etc.)	☐	☐	
Have you ever been treated for lung problems? (i.e. Asthma, Emphysema, Shortness of breath, etc.)	☐	☐	
Have you ever been treated for digestive tract problems? (i.e. Ulcer Disease, Hepatitis, Hiatal Hernia, etc.)?	☐	☐	
Have you ever had or been treated for Diabetes Mellitus or Thyroid Disease?	☐	☐	
Have you been treated for any prolonged or unusual bleeding or easy bruising?	☐	☐	
Have you ever had or been treated for neurological problems? (i.e. Seizures, Epilepsy, Stroke, TIA, etc.)	☐	☐	
Have you ever had or been treated for Creutzfeldt - Jakob disease?	☐	☐	

Please complete below surgical history:

Year	List Operations (Including Eye Surgeries)	Complications (if any)

I have answered the above questions to the best of my ability:

Patient Name (print) _____ Signature _____ Date _____ Time _____

DO NOT WRITE BELOW THIS LINE

Summary of Visits:

Visit #1 Date: _____ Reason for visit: _____ Nurses Name/Sig.: _____/_____ Date/Time: _____

Visit #2 Date: _____ Reason for visit: _____ Nurses Name/Sig.: _____/_____ Date/Time: _____

Visit #3 Date: _____ Reason for visit: _____ Nurses Name/Sig.: _____/_____ Date/Time: _____

Visit #4 Date: _____ Reason for visit: _____ Nurses Name/Sig.: _____/_____ Date/Time: _____

For Laser Procedures only: I attest that the patient is a suitable candidate and is able to safely proceed with the procedure.

Physician's Name: _____ Signature: _____ Date/Time: _____

Physician's Name: _____ Signature: _____ Date/Time: _____

BAPTIST EYE SURGERY CENTER
PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____

MR #: _____

Date: _____

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MEDICATION LIST

Allergies: ☐ No ☐ Yes *(include reaction)*: _____

☐ **No Home Medications**

Current medication (completed by patient/designee)
(Prescriptions, over the counter, herbals, patches and supplements)

Medication Name	Dose	How taken	How often

To be completed by Nurse

Visit #1 Date:		Visit #2 Date:		Visit #3 Date:	
Date last taken	Initials	Date last taken	Initials	Date last taken	Initials

DO NOT WRITE BELOW THIS LINE

Continue all home medications above as prescribed.

Continue all home medications above as prescribed EXCEPT aspirin or blood thinners.

Bactroban nasal ointment 2 times a day starting tonight, continue x 5 days apply to both nostrils. Do not put in your eyes.

Reviewed	Initials	Reviewed	Initials	Reviewed	Initials

Date	Time	Print Name	RN Signature	Initials

BAPTIST EYE SURGERY CENTER

MEDICATION LIST

Form #5416 Rev. 12/15

Patient Name: _____

MR #: _____

Date: