**CATARACT AND LASER CENTER CENTRAL**

**ADULT HEALTH QUESTIONNAIRE**

**Name: _____ Date of Birth: _____ Today's Date: _____**

Preferred Language: _____ Interpreter Needed? ☐ Yes ☐ No

Do you have an ***ACTIVE*** Health Care Proxy/Power of Attorney? ☐Yes ☐No
Are you able to make your own medical decisions and sign legal documents? ☐ Yes ☐ No

Have you or a blood relative ever have a reaction to anesthesia? ☐ Yes ☐ No
If yes, please explain:_____

Have you been to the Emergency Department or admitted to the Hospital in the past 2 months?
☐ Yes ☐ No If yes, please explain: _____

Will have a responsible adult to check on you for the first 24 hours after surgery? ☐ Yes ☐ No
Please provide their name and relation to you:
Name:_____ Telephone #: _____

**Smoking:** ☐ Never ☐ Yes, # of packs per day: _____
☐ Former # of years smoked: _____

**Alcohol:** ☐ Never ☐ Yes, # of Drinks/Week: _____
☐ Former Type: _____

**Illicit Drugs:** ☐ Never ☐ Yes
☐ Former ☐ Type: _____

**Caffeine Intake:** ☐ Yes ☐ No
Daily Intake: _____

**Do you see any specialists? ☐ Yes ☐ No**
If so, please list their name/phone # and specialty:
**1.**_____
**2.**_____
**3.**

**To the best of my knowledge, the information above is correct.**

Signature:_____

***This form is valid for 3 months from date originally signed.** **Updated 9.9.2021.DMT**