

TAMPA EYE & SPECIALTY CENTER – HEALTH QUESTIONNAIRE

NAME OF PATIENT: _____ DOB: ____/____/____ AGE: ____
HOME PHONE: ____-____-____ CELL PHONE: ____-____-____ SEX: ____ WT: ____ HT: ____
DATE OF SURGERY: ____/____/____ NAME OF SURGEON: _____

IF YOU ARE THE LEGAL GUARDIAN OF HAVE POWER OF ATTORNEY, PLEASE BRING DOCUMENTATION.

PERSON TO CONTACT IN CASE OF EMERGENCY:
NAME: _____ PHONE: ____-____-____ RELATIONSHIP: _____

DOCTORS WHO CARE FOR YOU:

PHYSICIAN: _____ SPECIALTY: _____ PHONE: ____-____-____
PHYSICIAN: _____ SPECIALTY: _____ PHONE: ____-____-____

LIST ALL ALLERGIES: (Drugs, Tape, Latex, Food, i.e.)

LIST ALL OPERATIONS YOU HAVE HAD:

List all medications you now take, including regular prescribed medications, herbals, diet pills, eye drops or over the counter medications: (Dosages & How Often) _____

	Please Circle		Comments:
1. Have you ever had angina or chest pain?	Yes	No	_____
2. Have you ever had a heart attack?	Yes	No	_____
3. Do you have a heart murmur or irregular heart beat?	Yes	No	_____
4. Do you have a pacemaker?	Yes	No	_____
5. Have you ever had high blood pressure?	Yes	No	_____
6. Have you ever had a stroke?	Yes	No	_____
7. Have you ever had any difficulty breathing?	Yes	No	_____
8. Do you have a cold?	Yes	No	_____
9. Do you have a cough?	Yes	No	_____
10. Have you had asthma?	Yes	No	_____
11. Have you ever had any type of cancer?	Yes	No	_____
12. Do you use assistance with walking?	Yes	No	Walker ___ Cane ___ Wheelchair ___
13. Do you have any implants or prosthesis?	Yes	No	_____
14. Do you have any skin conditions, rash, bruising or skin tears easily?	Yes	No	_____

ATTESTATION DATE INITIAL

VERBAL _____

WRITTEN



- | | | | |
|--|-----|----|-------------|
| 15. Do you smoke? If so, how many packs per day? | Yes | No | _____ |
| 16. Have you ever had kidney problems or on dialysis? | Yes | No | _____ |
| 17. Have you ever had Hepatitis? | Yes | No | Type: _____ |
| 18. Have you ever been jaundiced? | Yes | No | _____ |
| 19. Do you drink alcoholic beverages? If so, how much? | Yes | No | _____ |
| 20. Do you have diabetes? | Yes | No | _____ |
| 21. Have you ever had thyroid problems? | Yes | No | _____ |
| 22. Do you have any bleeding tendencies? | Yes | No | _____ |
| 23. Have you ever been anemic? | Yes | No | _____ |
| 24. Have you ever had epilepsy or seizures? | Yes | No | _____ |
| 25. Do you have weakness/numbness/paralysis
in your arms/legs? | Yes | No | _____ |
| 26. Could you be pregnant? | Yes | No | _____ |
| 27. Have you ever had a problem with anesthesia? | Yes | No | _____ |
| 28. Has a relative of yours had a problem with anesthesia? | Yes | No | _____ |
| 29. Do you wear contact lenses? | Yes | No | _____ |
| 30. Do you wear hearing aids? | Yes | No | _____ |
| 31. Do you have any chipped or loose teeth?
Dentures, caps, bridgework or braces? | Yes | No | _____ |
| 32. Have you had any recent exposure to TB? | Yes | No | _____ |
| 33. If you had a recent exposure, was your skin test positive? | Yes | No | _____ |
| 34. Do you have a chronic cough? | Yes | No | _____ |
| 35. Is there any blood with you cough? | Yes | No | _____ |
| 36. Do you have Parkinson's, Alzheimer's or arthritis? | Yes | No | _____ |
| 37. Have you ever had MRSA or VRE? | Yes | No | _____ |
| 38. Any other medical problems not listed above that
we should know about? (Please explain below) | Yes | No | _____ |

To the best of my knowledge, the above information is accurate and inclusive of my past and present medical history.

Signature: _____

Date: ____ / ____ / ____

TAMPA EYE & SPECIALTY SURGERY CENTER – INFORME SANITARIO

Nombre del Paciente _____ Edad _____ Sexo _____ Peso _____ Altura _____
 Name of the patient _____ Age _____ Sex _____ WT. _____ HT. _____

Fecha de Operación _____ Nombre del Cirujano _____
 Date of surgery _____ Name of Surgeon _____

Si usted es el tutor legal o tiene un poder, sírvase traer la documentación.
 If you are legal guardian or have power of attorney, please bring documentation.

Persona a quién contactar en caso de emergencia : _____
 Person to contact in case of emergency: _____ (Nombre) Name _____ (Teléfono) Phone Number _____

Médicos que lo asisten
 Doctors who care for you:

Nombre del médico: _____ Especialidad: _____ Teléfono _____
 Physician _____ Specialty _____ Phone _____

Nombre del médico: _____ Especialidad: _____ Teléfono _____
 Physician _____ Specialty _____ Phone _____

Mencione sus alergias (ej. Drogas, esparadrapos, látex, comidas)
 List all Allergies (i.e. Drugs, Tape, Latex, Food)

Mencione las operaciones que haya tenido
 List All Operations You Have had

Reacciones alérgicas
 Allergy Reactions

Mencione los medicamentos que está tomando actualmente incluyendo los recetados regularmente, hierbas, píldoras para adelgazar o medicamentos de venta libre (dosis y frecuencia)
 List all Medications you now take including regular prescribed medications, herbals, diet pills or over the counter medications (Dosages & How often)

	Please Circle Trace un círculo	Comment Comentario
1. ¿Ha tenido alguna vez angina o dolor de pecho? Have you ever had angina or chest pain?	No Yes (Si)	_____
2. ¿Ha sufrido algún ataque al corazón? Have you ever had a heart attack?	No Yes (Si)	_____
3. ¿Tiene usted un soplo al corazón o un ritmo cardíaco irregular? Do you have a heart murmur or irregular heart beat?	No Yes (Si)	_____
4. ¿Tiene usted un marcapasos? Do you have a pácemaker?	No Yes (Si)	_____
5. ¿Ha tenido alguna vez presión alta? Have you ever had high blood pressure?	No Yes (Si)	_____
6. ¿Ha tenido algún derrame cerebral? Have you ever had a stroke?	No Yes (Si)	_____
7. ¿Ha tenido alguna vez dificultad para respirar? Have you ever had any difficulty breathing?	No Yes (Si)	_____
8. ¿Tiene usted catarro? Do you have a cold?	No Yes (Si)	_____
9. ¿Tiene tos? Do you have a cough?	No Yes (Si)	_____
10. ¿Ha tenido asma alguna vez? Have you had asthma?	No Yes (Si)	_____
11. ¿Ha tenido algún tipo de cáncer? Have you ever had any type of cancer?	No Yes (Si)	_____
12. ¿Hay algún otro problema médico del cual deberíamos saber? (Describalo abajo) Any other medical problems not listed above that we should know about? (Please Explain below)	No Yes (Si)	_____

ATTESTATION DATE INITIAL _____

VERBAL _____

WRITTEN _____

- | | | | |
|--|----|----------|-------|
| 13. ¿Utiliza asistencia para caminar?
Do you use assistance with walking? | No | Si (Yes) | _____ |
| 14. ¿Tiene algún implante / prótesis?
Do you have any implants/prosthesis? | No | Si (Yes) | _____ |
| 15. ¿Tiene problemas de piel, sarpullido, hematomas, fragilidad?
Do you have any skin conditions, rash, bruising skin tears easily? | No | Si (Yes) | _____ |
| 16. ¿Fuma usted? ¿Cuántos paquetes por día?
Do you smoke? If so, how many packs per day? | No | Si (Yes) | _____ |
| 17. ¿Ha tenido problemas en los riñones o diálisis?
Have you ever had kidney problems or on dialysis? | No | Si (Yes) | _____ |
| 18. ¿Ha tenido hepatitis?
Have you ever had hepatitis? | No | Si (Yes) | _____ |
| 19. ¿Ha tenido ictericia?
Have you ever been jaundiced? | No | Si (Yes) | _____ |
| 20. ¿Toma usted bebidas alcohólicas? ¿Cuánto?
Do you drink alcoholic beverages? If so, how much? | No | Si (Yes) | _____ |
| 21. ¿Es usted diabético?
Do you have diabetes? | No | Si (Yes) | _____ |
| 22. ¿Ha tenido problemas de tiroides?
Have you ever had thyroid problems? | No | Si (Yes) | _____ |
| 23. ¿Tiende usted a sangrar?
Do you have any bleeding tendencies? | No | Si (Yes) | _____ |
| 24. ¿Ha estado anémico alguna vez?
Have you ever been anemic? | No | Si (Yes) | _____ |
| 25. ¿Ha tenido epilepsia o convulsiones?
Have you ever had epilepsy or seizures? | No | Si (Yes) | _____ |
| 26. ¿Siente usted debilidad / adormecimiento / parálisis en sus extremidades?
Do you have weakness/numbness/paralysis in your arms/legs? | No | Si (Yes) | _____ |
| 27. ¿Podría estar embarazada?
Could you be pregnant? | No | Si (Yes) | _____ |
| 28. ¿Ha tenido problemas con la anestesia alguna vez?
Have you ever had a problem with anesthesia? | No | Si (Yes) | _____ |
| 29. ¿Algún miembro de su familia ha tenido problemas con la anestesia?
Has a relative of yours had a problem with anesthesia? | No | Si (Yes) | _____ |
| 30. ¿Usa lentes de contacto?
Do you wear contact lenses? | No | Si (Yes) | _____ |
| 31. ¿Utiliza audífonos?
Do you wear hearing aids? | No | Si (Yes) | _____ |
| 32. ¿Tiene algún diente roto o flojo? ¿Dentadura postiza, coronas, puentes, frenillos?
Do you have any chipped or loose teeth?
Dentures, Caps, bridgework, braces? | No | Si (Yes) | _____ |
| 33. ¿Ha estado expuesto recientemente a la tuberculosis?
Have you had any recent exposure to TB? | No | Si (Yes) | _____ |
| 34. ¿Si estuvo expuesto, el análisis de su piel dio positivo?
If you had a recent exposure, was your skin test positive? | No | Si (Yes) | _____ |
| 35. ¿Sufre de tos crónica?
Do you have a chronic cough? | No | Si (Yes) | _____ |
| 36. ¿Hay rastros de sangre cuando tose?
Is there any blood with your cough? | No | Si (Yes) | _____ |
| 37. ¿Sufre de Parkinsons, Alzheimers, Artritis?
Do you have Parkinsons, Alzhemiers, Arthritis? | No | Si (Yes) | _____ |

Declaro a mi leal saber y entender, que la información anterior sobre mi historial médico actual y pasado es exacta.

To the best of my knowledge, the above information is accurate and inclusive of my past and present medical history.

Firma
Signature

Fecha
Date