Dudley Cataract Direct referral: Medicine Questionnaire

Name		Date of Birth	

This form is designed to help ensure the hospital have the information they need to consider your referral for cataract surgery. If you are unable to provide any of the information, please ask a member of your family or a friend to help. If you have difficulty completing the form, your optometrist can help you but bring along details of all your medication (either a repeat prescription list or the actual medicines.)

Section 1: Your general health

1. Do you have high blood pressure requiring treatment?		*Yes*		*No*
2. Do you have diabetes? (high blood sugar)		*Yes*		*No*
3. Do you have angina?		*Yes*		*No*
4. Have you had a heart attack within the last three months?		*Yes*		*No*
5. Do you have epilepsy or blackouts?		*Yes*		*No*
6. Do you suffer from head or neck stiffness?		*Yes*		*No*
7. Do you have recurrent breathing difficulties? (e.g.severe asthma,bronchitis etc)		*Yes*		*No*
8. Can you walk a single flight of stairs without getting short of breath?		*Yes*		*No*
9. Can you lie flat for up to 30 minutes?		*Yes*		*No*
If no: Is this due to shortness of breath?		*Yes*		*No*
Is this due to joint or muscle stiffness?		*Yes*		*No*
10. Do you suffer from panic attacks or claustrophobia?		*Yes*		*No*

Section 2: Medicine

1. Do you regularly take any of the following medicines?				
Heart medicine (e.g. Digoxin)		*Yes*		*No*
High blood pressure medicine		*Yes*		*No*
Anticoagulants or blood thinning medicines (e.g. Warfarin)		*Yes*		*No*
Tamulosin (Flomax)		*Yes*		*No*
Inhalers		*Yes*		*No*
Insulin or blood sugar tablets		*Yes*		*No*
2. Are you allergic to local anaesthetic?		*Yes*		*No*
3. Are you allergic to any medicine?		*Yes*		*No*
If yes, please give details:				
4. Please detail all medicine/tablets you are taking, or attach a repeat prescription (Continue overleaf if necessary)				