

## Cataract Assessment Service

### Health Questionnaire

**To help us provide a good service to you, please answer all the questions on this form.**

1. Name: .....

Address: .....  
.....

Date of birth: .....

2. Telephone number (if any): .....

Please tell us the days and times (between 9am and 6pm) when it would be convenient for us to contact you by phone:

.....

If you don't have a phone, please state the name of someone who is willing to talk to us on your behalf.

Their name: .....

Their telephone number: .....

Is this person a family member? Friend? Other representative? (Please circle the answer.)

Please sign here to give us your permission to talk to them about your case

Signature:.....

3. Are you on any medication? Yes / No

If yes, please write the names of your tablets and other medicines below, or enclose a recent list (for example, from the GP's surgery or pharmacy):

.....  
.....  
.....  
.....

4. Do you have diabetes? Yes / No

If yes, how is your diabetes controlled?

Insulin injections      Tablets                      Diet alone

5. Do have any breathing or chest problems?  
Yes /No

If yes, please tell us about them:.....

.....

6. Do you have high blood pressure? Yes / No

If yes, are you on any medication for it? Please list your tablets and other medicines:

.....

When did you last have your blood pressure measured?

.....

If you have not had your blood pressure measured in the last 6 months, please arrange for the practice nurse at your GP's practice to do this before you come for your assessment. (If your blood pressure is outside the normal range, you may not be able to be considered for cataract surgery.)

7. Do you have any heart problems? Yes / No

If yes, please tell us about them:

.....

8. Do you have any allergies or sensitivities? Yes / No

If yes, please say what they are:

.....

.....

9. Can you walk without help? Yes / No

If no, please say why:

.....

.....

10. Can you lie flat (with one pillow) and still for 30 minutes during the operation? Yes / No

11. You will need to have eye drops 4 times a day. Will you be able to put them in your own eyes? Yes / No

If no, is there someone who can do this for you?  
Yes / No

**12. Please give any other comments, or add any information you think we may need to know:**

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.....  
.....  
.....

**If you have any questions, please discuss these with the optometrist at your assessment, or contact your GP.**

