SIMON HORGAN FRCS FRCOphth

HEALTH QUESTIONNAIRE

NAME: ………………………………………………………………………. DOB: ……………………….

REGULAR MEDICATIONS:……………………………………………………………………………………

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ALLERGIES: …………………………………..   ……………………………………………………………

Have you had any previous eye surgery? Eg   Cataracts Y / N   Laser Y / N

DO YOU HAVE/ HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?: *Please give details where appropriate*	**YES**	**NO**
Heart problems, ie heart attack, irregular heartbeat, angina or pacemaker		
Any history of a stroke or a TIA		
High blood pressure		
Chest conditions, ie asthma, breathlessness, bronchitis or sleep apnoea		
Heartburn, acid reflux or hiatus hernia		
Diabetes: Type 1 or Type 2 *[please delete as appropriate]*		
Major surgery or serious illnesses *[please give details]*		
Have you ever tested positive for Hepatitis or Covid-19?		
Have you had Covid-19 vaccinations? **1st** **2nd**		