Ophthalmology Questionnaire

Patient's name: _____

Date of birth: _____ **NHI number:** _____

ALLERGIES – please detail (include substance and type of reaction)	
Please circle	
Yes / No	Plaster
Yes / No	Iodine/Savlon
Yes / No	Food (including seafood/shellfish)
Yes / No	Latex
General questions	
Please circle	
Yes / No	Unpredictable/persistent cough
Yes / No	Hepatitis A/B/C/HIV
Yes / No	Skin or other infection
Yes / No	Can you lie flat for 30-45 minutes?
Yes / No	Are you on any blood thinners?

Questionnaire completed by patient/family member/staff (*please circle)*

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

Name: _____

Signature: _____

Date: _____

Please include this questionnaire with other supporting documents when applying for cataract surgery

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