

Anesthesia questionnaire



Please fill in the front and back, mark with a cross accordingly and underline or mention what applies

Last Name **To be filled in by the anesthesiologist**
 First name No report required
 Date of birth Report requested from
 Height cm Weight kg Date: Initials:

Planned operation

Which operation is planned?
 Which doctor will operate on you
 Date of the planned operation?
 Have you had a check-up in the last 12 months? yes no
 If yes, with which doctor

Previous operations

Type of anesthesia

When? General
 Which one? Partial
 When? General
 Which one? Partial
 When? General
 Which one ? Partial

Did any incidents occur during anesthesia? yes no
 If so, which ones?

Did you experience discomfort? yes no

Nausea, vomiting, dizziness,
 shivering, breathing difficulties,
 swallowing difficulties
 Other?.....

Anesthesia incidents with blood relatives? yes no
 If so, which ones?

General questions

Have you had medical treatment recently? yes no

If so, why?

Do you smoke regularly yes no

If so, how much?

Do you drink alcohol regularly? yes no

If so, how much?

Do you take drugs? yes no

If so, which ones?

Could there be a pregnancy ? yes no

Have you ever had a blood transfusion? yes no

In the last 3 months yes no

Do you wear dentures yes no

Removable prosthesis, post tooth,
 jacket crown

Do you have loose teeth? yes no

Do you wear hearing aids? yes no

Do you have a pacemaker or defibrillator? yes no

Have you been or are you ill in the following organ systems?

Mark accordingly and underline as appropriate

Heart yes no

Heart attack, angina pectoris, heart defect, stent,
bypass, arrhythmia, inflammation of the heartmuscle
shortness of breath on exertion or when lying flat
or.....

Circulation yes no

High blood pressure
low blood pressure
or.....

Vessels yes no

Circulatory disorders, varicose veins Thromboses
or.....

Lungs and airways yes no

Pneumonia, tuberculosis, asthma, emphysema
chronic bronchitis, pulmonary embolism,
cough/expectoration, sleep apnea
or.....

Esophagus, stomach, intestines, yes no

liver, gallbladder
heartburn frequent vomiting, ulcer, reflux
digestive problems, gallstones, hepatitis
or.....

Metabolism yes no

Diabetes, gout, elevated blood lipids
or.....

Thyroid gland yes no

Hyperfunction or underfunction
or.....

Kidneys and urinary tract yes no

Kidney stones, inflammation, elevated kidney
values, dialysis, bladder infections
or.....

Musculoskeletal system yes no

Joint disease, back pain, shoulder or arm pain
or

Blood

Blood clotting disorder, (nosebleeds or
bleeding gums, hematoma, anemia, very
heavy menstrual bleeding

Nerves

Stroke, seizure disorders (epilepsy),
paralysis, sensory disturbances, forgetfulness,
poor concentration, headaches, migraines
or.....

Psyche yes no

depression, anxiety disorder
or.....

Allergy yes no

Hay fever, asthma, hypersensitivity to
medication, latex, food, iodine, adhesive plasters, contrast
agents, cosmetics, metals
or.....

Are you currently taking any medication? yes no

Please enclose a list of medications if available

Which ones ?.....

.....

.....

Other diseases not listed

.....

.....

.....

Preliminary telephone consultation with yes no

anesthesiologist requested

Telephone number.....

**I hereby confirm that I have filled in all information truthfully,
and that I have read the anesthesia questionnaire.**

**I am informed that I can discuss the anesthesia in advance by
telephone or in person. On the day of admission, the
anesthesiologist in charge will have a personal
conversation with me.**

Place.....

Date.....

Signature.....

Notes : (to be completed by anesthesiologist)

.....

.....

Please send this questionnaire as soon as possible with the stamped envelope or mail it to the operation center