AZ JAN PORTAELS
Algemeen Ziekenhuis Vilvoorde

DIENST ANESTHESIE

FORM 2

Name _____

First name _____

Date of birth ___/___/_____

Patiëntenvignet

PRE-OPERATIVE QUESTIONNAIRE

You will shortly undergo an anaesthetic procedure as part of a surgical treatment or examination at AZJP. Because of your safety and a perfect application of the anaesthetic procedure it is important for us to have a full understanding of your health status. It is crucial that you fill in this questionnaire (or have it filled in by your General Practitioner) as fully as possible.

Procedure/examination _____ Side of procedure ☐ Left ☐ Right

Weight: ____ kg Height: ____ cm Profession _____ Phone number _____ / _____

Which TYPE OF SURGERY did you have IN THE PAST? WHEN (year)?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Did any PROBLEMS occur? ☐ **Yes** ☐ **No**

☐ Nausea ☐ Vomiting ☐ Other problems? If so, which? _____

Do you easily get car sick? ☐ Yes ☐ No

Did any of your relatives ever have any problems during an operation? ☐ Yes ☐ No

If so, which? _____

Are you ALLERGIC to anything? ☐ **Yes** ☐ **No**

☐ Medications ☐ Latex or rubber ☐ Disinfectants

☐ Antibiotics ☐ Crustaceans ☐ Food

☐ Other. If so, to which substance(s) _____

Are you DIABETIC? ☐ **Yes** ☐ **No**

If so, are you on insulin? ☐ Yes ☐ No

Do you have a HEART DISEASE? ☐ **Yes** ☐ **No**

If so, which? _____

Who is your treating cardiologist? Dr. _____

When did you last see your cardiologist? ___ / ___ / _____

Did you ever have a heart attack? If so, when? ___ / ___ / _____ ☐ Yes ☐ No

Do you sometimes suffer from pressure on the chest? ☐ Yes ☐ No

If so, when? ☐ At rest ☐ During effort

Do you suffer from an irregular heartbeat? ☐ Yes ☐ No

Do you suffer from hypertension (high blood pressure)? ☐ Yes ☐ No

Do you have any problems with your heart valves? ☐ Yes ☐ No

Do you have a pacemaker or a defibrillator in situ? ☐ Yes ☐ No

If so, please bring along the identification card.

Do you have any BREATHING PROBLEMS? **(Wheezing, asthma, chronic bronchitis, …)**	**☐ Yes**	**☐ No**
If so, which? _____		
Who is your treating lung specialist? Dr. _____		
When did you last see your lung specialist? ___ / ___ / _____		
Do you use aerosols or inhalers?	☐ Yes	☐ No
Do you suffer from tightness of the chest or shortness of breath?	☐ Yes	☐ No
If so, when? ☐ At rest ☐ During effort		
Do you smoke?	☐ Yes	☐ No
If so, how much? _____		
Do you suffer from apnoea?	☐ Yes	☐ No
If so, do you use a CPAP device?	☐ Yes	☐ No
Do you suffer from any DIGESTIVE or STOMACH DISORDERS? **(Crohn's disease, colitis ulcerosa, acid reflux, stomach ulcer or bleeding, …)**	**☐ Yes**	**☐ No**
If so, which? _____		
Do you suffer from any NERVOUS SYSTEM DISORDER? **(Epilepsy, brain haemorrhage, cerebral venous thrombosis, temporary paralysis, muscle disorder, Parkinson's or Alzheimer's disease, myasthenia gravis, multiple sclerosis, …)**	**☐ Yes**	**☐ No**
If so, which? _____		
Do you suffer from tingling in hands or feet or loss of power in your upper or lower limbs? If so, please specify _____	☐ Yes	☐ No
Do you have a nerve stimulator?	☐ Yes	☐ No
Do you have any problems with the COAGULATION OF YOUR BLOOD?	**☐ Yes**	**☐ No**
Do you suffer from a coagulation disorder (haemophilia A, haemophilia B, Von Willenbrand's disease, …) If so, which? _____	☐ Yes	☐ No
Do you easily get bruises or nose bleedings?	☐ Yes	☐ No
Do you bleed ABNORMALLY long when you cut yourself or have a tooth pulled?	☐ Yes	☐ No
Do you take anticoagulants?	☐ Yes	☐ No
Do or did you have one or more of the following DISORDERS?	**☐ Yes**	**☐ No**
☐ Thyroid problems ☐ Kidney disease ☐ Sickle cell anaemia ☐ Glaucoma ☐ Lung embolism ☐ Deep venous thrombosis ☐ Bechterew's disease ☐ Reumatoïde arthritis		
Additional INFORMATION:		
Do you have an infectious disease?	☐ Yes	☐ No
☐ Hepatitis A/B/C ☐ TB ☐ HIV ☐ Other: _____		
Do you have a cold or a fever at the moment?	☐ Yes	☐ No
Are you possibly pregnant?	☐ Yes	☐ No
Do you have any loose teeth?	☐ Yes	☐ No
Do you have any dental implants, crowns, a tooth bridge?	☐ Yes	☐ No
Do you have a limited mouth opening?	☐ Yes	☐ No
Do you use drugs?	☐ Yes	☐ No
☐ Amphetamines ☐ Cannabis ☐ Heroin ☐ Other: _____		
Do you drink alcohol? If so, what and how much a day? _____	☐ Yes	☐ No
Do you have a will? If so, please bring a copy to the hospital.	☐ Yes	☐ No