



## Preoperative questionnaire

## Anaesthetic Department

Name: ..... First name: .....  
Proposed surgery (+ side if applicable): .....  
Date of Birth: ..... / ..... / ..... Date of surgery: ..... / ..... / .....  
Surgeon: .....  
Height (cm): ..... cm Weight(kg): ..... kg

### ■ Do you have any allergies?

No  Yes

#### What are you allergic to?

- Latex
- Antiseptics (Isobétadine,...)
- Pollen
- Animals
- Bananas or kiwi or tomatoes
- Bandages
- Contrast fluids (Iodine)
- Dust
- Antibiotics
- Other (ex: medicine): .....

#### What happens?

- Red skin or eruption or itch
- Runny nose
- Face swelling
- Asthma
- Hypotension or fainting
- Vomiting or diarrhoea
- Other: .....

### ■ Have you ever suffered from serious health problems? No Yes

Can you describe? .....

### ■ Consumption ?

- Tobacco  No  Yes  
Alcohol / beer / wine  No  Yes  
Recreational drugs  No  Yes

How many (cig/day) : ..... Stop since : .....

What and how many (glass/day) : .....

What and how much : .....

### ■ Do you have the following symptoms or diseases?

#### Lungs No Yes

- Asthma
- Chronic bronchitis / Emphysema
- Cough
- Nocturnal snoring
- Shortness of breath with moderate effort (two flights of stairs)
- Shortness of breath with light effort (walking 100 meters)
- Shortness of breath at rest or when you get dressed
- Sleep apnea (Bring your device at admission to hospital)

#### Heart No Yes

- Palpitations
- Chest pain radiating to neck or left arm with effort
- Chest pain radiating to neck or left arm at rest
- Other heart problem (infarction, cardiac intervention,...)
- High blood pressure
- Low blood pressure
- Swollen feet

#### Coagulation No Yes

- Frequent nose bleeding
- Frequent haematoma
- Bleeding gums when brushing teeth
- Wounds bleeding more than 5 minutes
- Liver problems (hepatitis, cirrhosis,...)
- Blood transfusion in the past
- Phlebitis / Lung emboli
- Medication affecting coagulation (Asaflow, Plavix, Sintrom, Fraxiparine, Xarelto,...)

#### Miscellaneous No Yes

- Diabetes  treated with insuline
- Thyroid disease
- Stomach ulcers
- Reflux of heartburn
- Brain problem (stroke, bleeding,...)
- Neurological disease (epilepsy, parkinson,...)
- Renal failure
- Recent intravenous injection of contrast fluids
- Corticoids taken during the last 3 months
- You are (maybe) pregnant

■ Right now, are you being treated (for a disease or something else) by your doctor / specialist, apart from the planned intervention ?

No  Yes Describe: .....

■ What medication do you take?

Name	Dosage	How many times per day	Name	Dosage	How many times per day

■ Have you had surgery before?  No  Yes

Name of surgery	Date (Year)	Type of anaesthesia	Name of surgery	Date (Year)	Type of anaesthesia

■ After these operations, have you suffered from...?

- Nausea or vomiting
- Bad wake up
- Difficulty breathing
- Sore throat
- Loss of sensibility (arm, leg,...)
- Memory loss
- Pain for more than 3 months after surgery
- Other : .....

■ Do you have...?

- An upper removable denture
- A lower removable denture
- A fixed upper denture
- A fixed lower denture
- Wobbly or fragile teeth
- Hearing aids
- Contact lenses

■ Has a member of your family had problems with anesthesia?  No  Yes

■ For children under the age of 12 : - was the childbirth premature?  No  Yes (... weeks)  
 - does the child have mental retardation?  No  Yes

■ Would you like to add some comments? .....

Signature