



Medical questionnaire for screening before general anesthesia

Personal data:

Name : _____ m / f
Address : _____
Area Code : _____
City : _____
Date of Birth : _____
BSN : _____
Phone nr : _____
Email : _____
Profession : _____
General Pract. : _____ Address: _____
Insurance : _____
Number : _____

Your height : _____ Your weight: _____

Current treatments and medication:

	yes	no
Are you currently being treated by your general pract. or a specialist?	0	0
Reason :		

Do you use medication?	0	0
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Which : _____

Are you allergic to:	yes	no
Latex :	0	0
Penicillin :	0	0
Iodine :	0	0
Soy :	0	0

Other allergies:	0	0
Which :		

Heart and breathing:	yes	no
Did you ever had a heart disease diagnosed?	0	0
If yes, which? _____		
Did you ever had a heart attack?	0	0
Are you under supervision of a cardiologist at the moment?	0	0
Do you ever experience pain or pressure at your chest?	0	0
If yes, does this happen during or after physical exercise?	0	0
After how many floors of climbing stairs you experience shortness of breath?		
(Please put a circle) ≤1 2 3 4 5≥		
Do you have shortness of breath when you lay down?	0	0
Did you ever had asthma diagnosed?	0	0
Did you ever had COPD or chronic bronchitis diagnosed?	0	0
Are you under supervision of a pulmonary dr at the moment?	0	0
Do you have wheezes on the chest?	0	0
Do you cough or give up slime?	0	0
Do you use inhalers for your lungs?	0	0
If yes, which ones and how often? _____		
Other diseases and problems:	yes	no
Do you have problems with :		
High blood pressure	0	0
Abdomen	0	0
Arms or legs	0	0
Something else, namely: _____		
Did you ever have thrombosis or lung embolism before?	0	0
If yes, when? _____		
Did the thrombosis or lung embolism occur spontaneously?	0	0
Possible reasons for having thrombosis or lung embolism: _____		

Did you ever had surgery?	0	0
Which date and what kind of surgery?		

Did you have excessive or postoperative bleeding?	0	0
Did you have problems with the general anesthesia?	0	0
What were these problems?		

Did you have problems with the spinal anesthesia?	yes	no
What were these problems?	0	0

Do you have disease of the thyroid gland?	0	0
If yes, when was the thyroid gland last tested in your blood?		
Date of latest blood test of the thyroid gland:_____		
Was the result of the blood test OK?	0	0
Do you have diabetes?	0	0
If yes, do you use:		
insulin	0	0
Tablets	0	0
Do you have ulcer disease in the stomach?	0	0
Do you have epilepsy?	0	0
If yes, when was your last attack?		

Did you ever had hepatitis, jaundice or liver disease?	0	0
Did you ever had problems with your kidneys?	0	0
What were these problems?_____		
Are the kidneys functioning well now?	0	0
Did you ever had a stroke or brain hemorrhage?	0	0
If yes, what are the residual symptoms you still have?		

Do you have multiple sclerosis or another nerve disease?	0	0
If yes, what are the current symptoms?_____		
Are you dependant of a wheelchair?	0	0
Do you have back problems (like hernia) or joint problems (like arthritis)?	0	0
Do you have stiffness in the neck or limited movement of the head?	0	0
Did you recently have an infection?	0	0
What kind of infection?		

Dentist:	yes	no
Did you ever have problems with the local anesthetics of the dentist?	0	0
What were these problems?		

	yes	no
Do you have limitations in opening your mouth completely?	0	0
Do you have difficulty swallowing?	0	0
Do you have a dental prosthesis?	0	0
Do you have any loose teeth?	0	0

Blood transfusion:

	yes	no
Did you ever have a blood transfusion?	0	0
When and why?		

Do you object to blood transfusions, even if it is life saving?	0	0
Do you have spontaneous or easy bruises/bleeding?	0	0

Family:

	yes	no
Are there any special or uncommon diseases in the family?	0	0
If yes, which?		

Are there any family members that had problems with general anesthesia?	0	0
If yes, what were these problems?		

Are there any family members that have a clotting disorder?	0	0
Are there any family members that have a blood disease?	0	0
Are there any family members that had thrombosis or pulmonary embolus?	0	0

If yes, which family member? _____

Are there any nerve or muscle diseases in the family?	0	0
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If yes, which disease in which family member? _____

Do you have a specific syndrome or genetic disorder?	0	0
If yes, which specific syndrome or genetic disorder?		

Pregnancy, drugs and exercises

	yes	no
Do you use a birth control pill?	0	0
Are you pregnant?	0	0
Do you smoke?	0	0
I smoke sigarets / cigars per day		
Do you use alcohol?	0	0
I drink units of alcohol per day		
Do you use drugs?	0	0
Which drugs? _____		

How many times per week:

	yes	no
Do you practice a sport?	0	0
How many times per weekxmin		
Do you have objections against us acquiring medical information from your family dr or specialist?	0	0
Do you use bisphosphonates (drugs against bone loss)	0	0

If yes, for how long?_____

Is there any subject that wasn't addressed in this questionnaire?	0	0
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If yes, please specify?

MRSA/MDRO*	yes	no
Have you been in a hospital in another county in the last year? (This includes Belgium or Germany)	0	0
Do you work at an animal farm or have you been there recently?	0	0
Do you have regular contact with cattle because of your work or private?	0	0
Do you have a MDRO* in or on your body?	0	0
Have you been in a hospital last year where there was a MDRO* outbreak?	0	0
Do you have regular contact with a person who has a MDRO*?	0	0

(*MDRO = a MultiDrug Resistant microOrganism, usually a bacteria)

Please only fill in this part if you are 70 years or older	yes	no
Do you have memory problems?	0	0
Did you need help with your personal care in the last 24 hours when you normally don't need it?	0	0
Were you ever confused after / during illness or hospitalization?	0	0

Contact:

Who can we reach out to if there are any particularities:

Name:_____ Phone nr:_____

What is your relation with this person:_____

The person who signed this questionnaire declares that everything has been answered correctly.

Date:

Name:

Signature: