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Medical questionnaire for screening before general anesthesia

Personal data of your child:

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

Your child's height : _____ Your child's weight: _____

Current treatments and medication:

	yes	no
Is your child currently being treated by your general pract. or a specialist?	0	0
Reason : _____		

Does your child use medication?	0	0
Which : _____		

	yes	no
Is your child allergic to:		
Latex :	0	0
Penicillin :	0	0
Iodine :	0	0
Soy :	0	0
Other allergies:	0	0
Which : _____		

Heart and breathing:	yes	no
Did your child ever had a heart disease diagnosed?	0	0

If yes, which? _____

Did your child ever had a heart attack?	0	0
Is your child under supervision of a cardiologist at the moment?	0	0
Does your child 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 your child experience shortness of breath? (Please put a circle) ≤1 2 3 4 5≥		
Does your child have shortness of breath when you lay down?	0	0
Did your child ever had asthma diagnosed?	0	0
Did your child ever had COPD or chronic bronchitis diagnosed?	0	0
Is your child under supervision of a pulmonary dr at the moment?	0	0
Does your child have wheezes on the chest?	0	0
Does your child cough or give up slime?	0	0
Do your child use inhalers for the lungs?	0	0
If yes, which ones and how often? _____		

Other diseases and problems:	yes	no
Does your child have problems with :		
High blood pressure	0	0
Abdomen	0	0
Arms or legs	0	0
Something else, namely: _____		

Did your child ever have thrombosis or lung embolism before?	0	0
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If yes, when? _____

Did the thrombosis or lung embolism occur spontaneously?	0	0
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Possible reasons for having thrombosis or lung embolism: _____

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

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

Did your child have problems with the spinal anesthesia?	yes 0	no 0
What were these problems?		
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Does your child have disease of the thyroid gland?	0	0
If yes, when was the thyroid gland last tested in the blood?		
Date of latest blood test of the thyroid gland:_____		
Was the result of the blood test OK?	0	0
Does your child have diabetes?	0	0
If yes, does your child use: insulin	0	0
Tablets	0	0
Does your child have ulcer disease in the stomach?	0	0
Does your child have epilepsy?	0	0
If yes, when was your child's last attack?		
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Did your child ever had hepatitis, jaundice or liver disease?	0	0
Did your child ever had problems with the kidneys?	0	0
What were these problems?_____		
Are the kidneys functioning well now?	0	0
Did your child ever had a stroke or brain hemorrhage?	0	0
If yes, what are the residual symptoms your child still has?		
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Does your child have multiple sclerosis or another nerve disease?	0	0
If yes, what are the current symptoms?_____		
Is your child dependant of a wheelchair?	0	0
Does your child have back problems or joint problems (like arthritis)?	0	0
Does your child have a stiff neck or limited movement of the head?	0	0
Did your child recently have an infection?	0	0
What kind of infection?		
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Dentist:	yes	no
Did your child ever had problems with the local anesthetics of the dentist?	0	0
What were these problems?		
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	yes	no
Does your child have limitations in opening the mouth completely?	0	0
Does your child have difficulty swallowing?	0	0
Does your child have a dental prosthesis?	0	0
Does your child have any loose teeth?	0	0

Blood transfusion:

	yes	no
Did your child ever had a blood transfusion?	0	0
When and why?		

Do you object to blood transfusions, even if it is life saving?	0	0
Does your child 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? _____

Does your child have a specific syndrome or genetic disorder?	0	0
If yes, which specific syndrome or genetic disorder?		

Exercise

	yes	no
Does your child 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
Is there any subject that wasn't addressed in this questionnaire?	0	0
If yes, please specify		

MRSA/MDRO*	yes	no
Has your child been in a hospital in another county in the last year? (This includes Belgium or Germany)	0	0
Has your child been in an animal farm recently?	0	0
Does your child have regular contact with cattle?	0	0
Does your child have a MDRO* in or on the body?	0	0
Has your child been in a hospital last year where there was a MDRO* outbreak?	0	0
Does your child have regular contact with a person who has a MDRO*? (*MDRO = a MultiDrug Resistant microOrganism, usually a bacteria)	0	0

Contact:

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

Name: _____ Phone nr: _____

What is your child's relation with this person: _____

The parent/caregiver who signed this questionnaire declares that everything has been answered correctly.

Date:

Name:

Signature: