

First name:
Surname:
Date of birth:
Phone number and/or e-mail address:
The kind of surgical procedure:

Ladies and gentlemen,
To limit the risk of perioperative complications, please acquaint your anaesthesiologist with your health condition. This questionnaire serves this purpose. The anaesthesiologist will qualify you to the anaesthesia and choose the most suitable kind based on the information and the kind of your disease.

Body weight: kg
Height: cm

1. Have you been ill in the last 6 months?
Yes / No
2. If you have, please list the disease(s).
3. Do you take any drugs?
No /Yes
4. If you take any drugs, please list them.
5. Do you suffer or have you suffered from heart diseases (ischaemic heart disease, heart attack, myocarditis or other diseases)?
No
Yes Please describe the problem
6. Have you experienced chest pains in the last year?
Yes / No
7. Have you ever had arrhythmias or palpitations?
No / Yes
8. Do you suffer from hypertension?
No
Yes Since when?
9. Do you suffer from lung diseases (asthma, COLD, emphysema, tuberculosis, pneumonia or any other disease)?
No / Yes
10. Have you had cough in the last 4 weeks or have you had a cold?
No / Yes
11. Do you smoke?
No
Yes Since when? How many cigarettes a day?
12. Have you ever had problems with the urinary tract (nephrolithiasis, kidney infections or alike)?
No
Yes Please describe the problem
13. Do you suffer from diabetes?
No / Yes
14. Do you suffer from thyroid diseases (nontoxic goiter, hypothyroidism, hyperthyroidism)?
No
Yes Please describe the treatment
15. Have you suffered from hepatitis, cholelithiasis, liver cirrhosis or other liver diseases?
No
Yes Please describe the problem
16. Have you ever had gastrointestinal problems (peptic ulceration, GERD, heartburn or others)?
No
Yes Please describe the problem
17. Do you drink alcohol regularly?
No
Yes What kind? How much?

18. Have you ever suffered from nervous system diseases (stroke, convulsions, epileptic attacks, loss of consciousness, double vision, meningitis or other diseases)?
No
Yes Please describe the problem
19. Have you ever had spine/head injuries, bone fractures or a traffic accident?
No
Yes Please describe the problem
20. Have you or members of your family ever had muscle diseases, muscle strength weakening, myopathies?
No / Yes
21. Have you ever had blood diseases, coagulation system diseases (tendency to bleed, extensive bruises, long lasting nose bleeding or other)?
No
Yes Please describe the problem
22. Are you allergic to anything?
No
Yes To what? What are the symptoms?
23. Do you suffer from porphyria?
No / Yes
24. Have you ever undergone a surgical procedure/ been in anaesthesia?
No
Yes Please put down the kind of surgery. When was it?
25. How did you tolerate anaesthesia?
Badly / Well
26. Have there been any cases of anaesthesia intolerance in the family?
Yes Please describe the problem
No
27. Do you have braces, dental plates or dental infections?
No / Yes
28. Do you have a tendency for nausea or to vomit?
No / Yes
29. Have you recently used stimulants or drugs?
No / Yes
30. Do you have any other health problems not mentioned above?
No
Yes Please describe the problem