Anaesthetic Department

Preoperative questionnaire

KLINIEK SINT-JAN
CLINIQUE SAINT-JEAN

Name : …….. Gastroscopy / Colonoscopy

First name : …….. Date of exam :

Date of Birth : / / Height(cm) : ……..Weight(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** How many (cig/day) : ……. Stop since : ……

Alcohol / beer / wine **◘ No ◘ Yes** What and how many (glass/day) : ……

Recreational drugs **◘ No ◘ Yes** 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
- □ Corticoïds taken during the last 3 months
- □ You are (maybe) pregnant

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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

If you suspect a coronary or valvular heart disease or a heart failure, could you plan a more in-depth review by a cardiologist ?

Would you like to add some comments? ……

……

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Signature

If you are looking for more information, please visit our website : **www.anesthesie-sj.be**