

Preoperative Anesthesia Questionnaire

Full name: _____

Date of birth (age): _____

Home address: _____

Telephone number: _____

Weight and height: _____

Please read the questionnaire carefully and answer all the questions.

Dear Patient,

Surgical procedures and painful examinations are performed under anesthesia. The anesthesiologist is responsible for your care throughout the entire perioperative period. Completing this questionnaire accurately and thoroughly will help us properly assess your health before anesthesia. Each question relates to certain risk factors associated with anesthesia.

***Please underline the appropriate answer.**

1. Have you received medical treatment during the past 12 months? YES / NO

If yes, what was the reason/diagnosis?

2. Have you recently taken or are you currently taking any medications?

YES / NO

If yes, which ones?

3. Are you currently taking any dietary supplements? YES / NO

If yes, which ones?

4. Have you ever undergone surgery? YES / NO

If yes, when and for what reason?

5. Have you ever experienced any complications during anesthesia? YES / NO

If yes, what kind?

6. Have any of your close relatives experienced unexplained complications related to anesthesia? YES / NO

If yes, what kind?

**7. Do you have any muscle disorders or muscle weakness (e.g. myasthenia)?
YES / NO**

8. Have any of your close relatives had or currently have such conditions?

YES / NO

9. Do you have porphyria? YES / NO

10. Is your physical capacity limited? Do you develop bluish discoloration (cyanosis) during strenuous physical activity? Do you experience severe shortness of breath during physical activity? YES / NO

11. Have you been diagnosed with a heart defect or any other heart condition?

YES / NO

If yes, what condition?

12. Do you frequently suffer from bronchitis? YES / NO

13. Do you have any other lung or respiratory conditions? YES/ NO

If yes, which ones?

14. Have you ever had jaundice (other than physiological jaundice)? YES / NO

15. Do you have an increased tendency to bleed or have you ever experienced abnormal bleeding? YES / NO

16. Do you have a tendency to develop extensive or unexplained bruising?

YES / NO

17. Do you currently have or have you ever had urinary tract infections?

YES / NO

If yes, what kind and when?

18. Do you have any diseases or disorders of the nervous system?

YES / NO

If yes, which ones?

19. Have you ever experienced seizures or convulsions during a fever? Have you ever had non-febrile seizures? YES / NO

If yes, when?

20. Do you suffer from any allergies? Have you ever developed a rash or other allergic reaction after taking medications or exposure to other substances?

YES / NO

If yes, which medications or substances?

21. Do you have diabetes? YES / NO

22. Do you have any loose teeth, dental prostheses, crowns, bridges, or dental implants? YES / NO

If yes, please specify:

23. Additional information (e.g. any other medical conditions, previous illnesses, or relevant health information not listed above):

Thank you.