

PREOPERATIVE ANESTHESIOLOGICAL QUESTIONNAIRE

SURNAME _____ **NAME** _____

Birth date: _____ Gender M/ F _____ Weight (kg) _____ Height (cm) _____

A) Family history

- | | | | |
|--|-------------------------|-----|----|
| 1. In the family diseases are present: | - DIABETES? | YES | NO |
| | - FAVISM? | YES | NO |
| | - Mediterranean anemia? | YES | NO |
| | - MYOPATHIES? | YES | NO |
| | - HEMOPHILIA? | YES | NO |
| | - OTHERS? _____ | | |

B) Birth and first months

- | | | |
|---|-----|----|
| 1. Was the baby born prematurely? (specify, how many weeks _____) | YES | NO |
| 2. Did he have any problems (difficulty breathing, etc.) in the first few weeks of life?
(specify _____) | YES | NO |
| 3. Very intense neonatal jaundice? | YES | NO |

C) Diseases, interventions, anaesthesia

- | | | |
|---|-----|----|
| 1. Is he suffering from congenital diseases? (specify _____) | YES | NO |
| 2. What disease did he have? _____
_____ | | |
| 3. What surgeries did he undergo? _____
_____ | | |
| 4. Has he ever experienced LOCAL ANESTHESIA?
(specify _____) | YES | NO |
| 5. Has he ever experienced GENERAL ANESTHESIA?
(specify _____) | YES | NO |
| 6. Did he have COMPLICATIONS from surgery or anesthesia?
(specify _____) | YES | NO |
| 7. Has anyone IN THE FAMILY had COMPLICATIONS related to ANESTHESIA?
(specify _____) | YES | NO |

D) Drugs and allergies

- | | | |
|---|-----|----|
| 1. Is he taking ANY MEDICATION? if YES, which? _____ | NO | |
| 2. Has he had ANY ALLERGIC REACTIONS (drugs, chemicals, insect bites, etc.)?
(specify _____) | YES | NO |

E) General health and miscellaneous

- | | | |
|--|-----|----|
| 1. Does he have to follow a special diet/FOOD? | YES | NO |
|--|-----|----|

(specify and bring specific foods/pappas _____)

- | | | |
|--|-----|----|
| 2. Has he ever had acetone? _____ | YES | NO |
| 3. Does he have TEETH that are about to fall out? (specify _____) | YES | NO |
| 4. Is he having difficulty opening his MOUTH? _____ | YES | NO |
| 5. Does he have an orthodontic device? (evaluate with your dentist)
(specify _____) | YES | NO |
| 6. Does he suffer/have suffered from HEART problems, arrhythmia, etc)?
If YES: A recent cardiac report is required: specify _____ | YES | NO |
| 7. Does he often suffer from coughing/difficulty BREATHING?
If YES: a recent pulmonary report is required: specify _____ | YES | NO |
| 8. Does he have PROLONGED BLEEDING following cuts, tooth extractions, etc? Does he often lose
nose/gum blood? Does he bruise easily?
Specification and if YES: evaluate any further examinations with the Family doctor
_____ | YES | NO |
| 9. Does he often suffer from INFECTIONS?
(specification _____) | YES | NO |
| 10. Has he ever had a TRANSFUSION? _____ | YES | NO |
| 11. Has he ever had LOSS OF CONSCIOUSNESS? _____ | YES | NO |
| 12. Has he ever had SEIZURES? (specification _____) | YES | NO |

F) Medical-surgical device

1. Is he a carrier of a Baclofen pump, peritoneal ventricular diversion, DBS, etc.? (specify and if applicable, request a recent evaluation certifying that the system is functioning properly or any specific need) _____ YES NO

G) Others: _____

Date _____ Filled by: _____

Signature _____