Anaesthesia survey

Dear patient!

Date: _ _ _ _ _ _ _ _ _ _ _ _ _

Please complete this questionnaire carefully and completely, so we can provide perfect service and meet all your op-related needs.

Please bring these forms of ID, if held, with you:

- Anaesthesia pass
- Living will
- Stent pass / implant pass
- Allergy pass
- Power of attorney for healthcare
- Cardiac pacemaker pass

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date of birth: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Profession: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Height: --------- Weight: --------- kg

Please mark with a cross where applicable and explain in detail:

1 | Any earlier operations?

◯ **Yes** ◯ **No**

If **Yes**, which and when?

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2 | Did you have post-operative difficulties?

◯ **Yes** ◯ **No**

If **Yes**, which?

☐ Nausea/vomiting ☐ Breathing difficulties

☐ Circulatory problems ☐ Shivering

other:

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3 | Have any of your blood relatives ever had anaesthesia-related complications?

◯ **Yes** ◯ **No**

4 | Can you climb up two flights of stairs without stopping and without breathing difficulty or heart problems?

◯ **Yes** ◯ **No**

5 | Have you ever had blood supplied (transfusions)?

◯ **Yes** ◯ **No**

If **Yes**, were there any complications and if yes, which?

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6 | Do you have any allergies or intolerances?

◯ **Yes** ◯ **No**

If **Yes**, which?

☐ Latex (rubber) ☐ Antibiotics (e.g. penicillin)

☐ Iodine ☐ Nickel ☐ Food

other:

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7 | Are there any medicines which you regularly take?

◯ **Yes** ◯ **No**

If **Yes**, which?

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8 | Blood-thinning medicines?

◯ **Yes** ◯ **No**

If **Yes**, which?

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9 | Over-the-counter medicines (non-prescription), non-drug compounds?

◯ **Yes** ◯ **No**

If **Yes**, which?

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10 | Do you or did you smoke?

◯ **Yes** ◯ **No**

If **Yes**, how many cigarettes per day: .....
If **Yes**, for how many years: .....
If formerly **Yes**, non-smoker since
how many years: .....

11 | Do you drink alcohol regularly?

◯ **Yes** ◯ **No**

If **Yes**, what and how much per day?

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12 | Do you take drugs?

◯ **Yes** ◯ **No**

If **Yes**, which?

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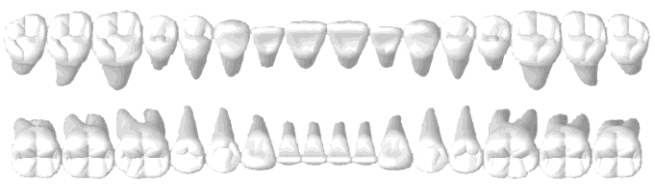
13 | Are you hard of hearing? ◯ **Yes** ◯ **No**

14 | Do you have wobbly or damaged teeth?

If **Yes**, which (mark a cross):



15 | Do you wear dentures?

◯ **Yes** ◯ **No**

16 | Does the wound healing take excessively long in your case?

◯ **Yes** ◯ **No**

17 | Has any blood clotting disorder ever been diagnosed for you or one of your blood relatives?

◯ **Yes** ◯ **No**

18 | Have you noticed any of the following types of bleeding without good reason?

☐ Nosebleeds
☐ Bruises without any impact
☐ Bleeding in joints, muscles, soft tissue
☐ excessive bleeding after a tooth extraction
☐ excessive bleeding after earlier operations or cut injuries

19 | Did you or one of your blood relatives ever have thrombosis or (pulmonary) embolism?

◯ **Yes** ◯ **No**

Only to be answered by female patients:

20 | Do you or did you have excessively heavy periods?

☐ Lasting longer than 7 days
☐ more than 7 tampons/sanitary towels (of normal size) per day

21 | Could you be pregnant?

◯ **Yes** ◯ **No**

22 | Have you had a cold in the past 2 weeks or been seriously ill?

◯ **Yes** ◯ **No**

23 | Have you or did you ever have one of the following infectious diseases, if Yes, which?

☐ HIV ☐ Hepatitis ☐ Tuberculosis

24 | Do you have any foreign objects either on or in your body?

◯ **Yes** ◯ **No** If **Yes**, which?

☐ Stent ☐ Pacemaker
☐ Cardioverter-defibrillator ☐ Piercing

other:

Do you suffer or have you ever suffered from one of the following Illnesses?

25 | **High blood pressure** ◯ Yes ◯ No
26 | **Diabetes** ◯ Yes ◯ No
If **Yes**, do you inject insulin? ◯ Yes ◯ No
27 | **Heart attack** ◯ Yes ◯ No
If **Yes**, within the past 6 weeks? ◯ Yes ◯ No
If **Yes**, was a cardiac catheter examination performed? ◯ Yes ◯ No
28 | **Chest pains when at rest** ◯ Yes ◯ No
29 | **Chest pains only during exertion** ◯ Yes ◯ No
30 | **Heart failure** ◯ Yes ◯ No
31 | **Water in lungs or legs** ◯ Yes ◯ No

32 | **Cardiac arrhythmia (e.g. Atrial fibrillation)** ◯ Yes ◯ No
33 | **Heart valve disease** ◯ Yes ◯ No
34 | **Lung disease** ◯ Yes ◯ No
35 | **Bronchial asthma** ◯ Yes ◯ No
36 | **Bronchitis or COPD** ◯ Yes ◯ No
If **Yes**, do you need an oxygen machine: ◯ Yes ◯ No
38 | **Sleep apnoea** ◯ Yes ◯ No
If **Yes**, do you use a CPAP mask at night? ◯ Yes ◯ No
39 | **Kidney disease** ◯ Yes ◯ No

40 | **Liver disease** ◯ Yes ◯ No
41 | **Gastrointestinal disorder** ◯ Yes ◯ No
42 | **Infectious disease** ◯ Yes ◯ No
43 | **Thyroid disease** ◯ Yes ◯ No
44 | **Cardiovascular disorders** ◯ Yes ◯ No
45 | **Nervous system disorders** ◯ Yes ◯ No
46 | **Dementia** ◯ Yes ◯ No
47 | **Stroke or TIA** ◯ Yes ◯ No
If **Yes**, within the past 6 weeks? ◯ Yes ◯ No
48 | **Nervous disorder or Mental illness** ◯ Yes ◯ No

49 | **Muscle disease** ◯ Yes ◯ No
50 | **Disease of Musculoskeletal system** ◯ Yes ◯ No
51 | **Glaucoma** ◯ Yes ◯ No
52 | **other disease, not included in the above:** ◯ Yes ◯ No
If **Yes**, which?

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53 | Do you have a power of attorney for healthcare? ◯ Yes ◯ No
54 | Do you have a living will? ◯ Yes ◯ No

Please read the written information sheet which gives you basic information on the following explanatory meeting with the anaesthetist or watch the explanatory anaesthesia film at:

https://www.youtube.com/channel/UCyIaSac-bZ-fCGgJu0uN68w/playlists

If you want to skip an explanation of the risk, please inform your anaesthesiologist accordingly. The film or information sheet are not intended as a substitute for your individual discussion with the anaesthetist.

In accordance with the recommendations of the “Pre-operative patient management” and “Perioperative Clotting” working groups of the Austrian Society of Anaesthesiology, Resuscitation and Intensive Care.