PREOPERATIVE QUESTIONNAIRE (ADULTS)

Surname :
Given names :
Date of birth :

Which operation have you been admitted for : right O left O

Date :

Length :	Weigth :	Blood group :

Have you ever had surgery ?	YES o	NO o	COMMENTS
Were there any complications ?	YES o	NO o	COMMENTS
Did you have a general anaesthetic ?	YES o	NO o	COMMENTS
Did you have a local anaesthetic ?	YES o	NO o	COMMENTS
Did you have a general anaesthetic ?	YES o	NO o	COMMENTS
Did you have a local anaesthetic ?	YES o	NO o	COMMENTS
Were there ever any problems with you or a family member concerning the anaesthetic ?	YES o	NO o	COMMENTS
Have you ever had a blood transfusion ?	YES o	NO o	COMMENTS
Do you bruise easily or do you bleed for a long time after a trauma or dental treatment?	YES o	NO o	COMMENTS
Have you ever had an accident and did you go into a coma?	YES o	NO o	COMMENTS
Are you allergic to any medication ?	YES o	NO o	COMMENTS
Please specify :			
Are you sensitive to any other products ?	YES o	NO o	COMMENTS
Do you smoke ?	YES o	NO o	COMMENTS
Do you use alcohol ?	YES o	NO o	COMMENTS
Do you wear contact lensens ?	YES o	NO o	COMMENTS
Do you have dentures or a hearing aid ?	YES o	NO o	COMMENTS
For female patients only : are you using a contraceptive medicine ?	YES o	NO o	COMMENTS
Is there a possibility you are pregnant ?	YES o	NO o	COMMENTS
Is there any other relevant information you wish to include ?	YES o	NO o	COMMENTS

Do you have any questions ?	YES o	NO o	COMMENTS
Do you suffer from one of the following conditions :			
diabetes……..	YES o	NO o	COMMENTS
heart disorders…….	YES o	NO o	COMMENTS
high or low blood pressure……..	YES o	NO o	COMMENTS
swollen ankles (edema)……..	YES o	NO o	COMMENTS
stomach disorders…….	YES o	NO o	COMMENTS
kidney disorders……	YES o	NO o	COMMENTS
thyroid disorders……	YES o	NO o	COMMENTS
varicose veins……	YES o	NO o	COMMENTS
shortness of breath ……..	YES o	NO o	COMMENTS
chronic bronchitis……..	YES o	NO o	COMMENTS
asthma ……	YES o	NO o	COMMENTS
Do you have a cold at the moment?	YES o	NO o	COMMENTS
Are you under psychiatric care?	YES o	NO o	COMMENTS
Do you suffer from any other conditions or disease not mentioned above ?	YES o	NO o	COMMENTS

Please specify :

Which medicines do you take?

We would like to thank you for your cooperation.

Date :

Signature :

(preopquestad)

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