Anesthesievragenlijst voor volwassenen- Engels / English translation Anaesthesia questionnaire for adults

Anaesthesia questionnaire for adults

Take this completed form with you when you visit the pre-operation outpatient examination (POE)

Remember to bring your Current Medication Overview (Actueel Medicijn Overzicht, AMO).

It is important for us to know which medication you are using. For that reason we ask that you take your Current Medication Overview (AMO) with you to the hospital. *Please note: you are obligated to take your AMO with you to the POE surgery hour. If you do not have your AMO with you the specialist will not be able to help you.*

You have to pick up this AMO at your own chemist, as the chemist will want to discuss it with you. **Compare your AMO with your current medication and change it if necessary**. When you are discharged from the hospital you will be given a new AMO.

If necessary you will also receive a prescription. We then call it an AMO-R. You take this AMO-R with you to a chemist. You will then be provided with your new medication.

Form completed on: (date) _____ Tick where appropriate

Do you take painkillers that can be obtained without prescription? ☐ yes/ ☐ no

Do you take St. Johns wort? ☐ yes/☐ no

Do you use medication? ☐ Yes ☐ No

If yes, request a (free) overview of your medication from your chemist and add it to the questionnaire.

Name of medication and potency (to be filled in by yourself)	Dose (to be filled in by yourself)	Continue/stop (to be filled in by anaesthesiologist)

Have you had surgery before? ☐ Yes ☐ No

If yes, for what?

For what/condition	When	Which hospital

Have you ever had problems with anaesthesia or narcosis? ☐ Yes ☐ No

If yes, what kind of problem?

Are you receiving treatment from your general practitioner or specialist for a different condition? ☐ Yes ☐ No

If yes, what kind of treatment?

Are you hypersensitive for/allergic to specific substances, for example antibiotics/iodine/latex/rubber/soy/peanuts? ☐ Yes ☐ No

If yes, what?

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many glasses a week?

Do you smoke? ☐ Yes ☐ No

If yes, how many cigarettes/cigars a day?

Do you use drugs? ☐ Yes ☐ No

If yes, which and how much per week?

Do you practice sports? ☐ Yes ☐ No

Can you dress and undress yourself without becoming short of breath? ☐ Yes ☐ No

Can you perform small household tasks (vacuuming, cleaning) without complaints? ☐ Yes ☐ No

Can you walk or ride a bike for a distance without complaints? ☐ Yes ☐ No

Can you perform heavy labour without complaints? ☐ Yes ☐ No

Are you being treated for high blood pressure? ☐ Yes ☐ No

Do you sometimes feel pressing pain on the chest? ☐ Yes ☐ No

If yes, does the pain radiate to the left arm or jaw? ☐ Yes ☐ No

Have you ever suffered from a heart attack? ☐ Yes ☐ No

If yes, when?

Do you sometimes suffer from palpitations of the heart? ☐ Yes ☐ No

Are you short of breath during exertion, for example when climbing the stairs? ☐ Yes ☐ No

Are you familiar with a lung disease (asthma/COPD/pulmonary emphysema)? ☐ Yes ☐ No

Do you suffer from OSAS? ☐ Yes ☐ No

If yes, do you have a CPAP machine? ☐ Yes ☐ No

Do you have to cough regularly? ☐ Yes ☐ No

If yes, do you cough up slime? ☐ Yes ☐ No

Have you had a prednisone course of treatment in the past 3 months? ☐ Yes ☐ No

Do you often suffer from stomach complaints? ☐ Yes ☐ No

Do you have jaundice (=hepatitis)? ☐ Yes ☐ No

Do you have a kidney condition? ☐ Yes ☐ No

Have you ever had a cerebral haemorrhage or cerebral infarction? ☐ Yes ☐ No

If yes, when?

Have you ever had epileptic attack (fit or seizure)? ☐ Yes ☐ No

If yes, when?

Do you have problems with your joints or muscles? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Do you have a thyroid gland condition? ☐ Yes ☐ No

Do you have a neurostimulator? ☐ Yes ☐ No

Do you bruise easily? ☐ Yes ☐ No

Do your suffer from continued bleeding, for example after pulling a tooth? ☐ Yes ☐ No

Have you ever had thrombosis or pulmonary embolism? ☐ Yes ☐ No

Could you be pregnant? ☐ Yes ☐ No

Are you possibly a carrier of the HIV/AIDS virus? ☐ Yes ☐ No

Do you wear a set of dentures? ☐ Yes ☐ No

Upper teeth, lower teeth or both?

Do you have implants or a dental plate in your mouth ☐ Yes ☐ No

Do you have loose teeth or molars? ☐ Yes ☐ No

Do you have crowns or bridgework? ☐ Yes ☐ No

Is it difficult for you to open your mouth wide? ☐ Yes ☐ No

Do you suffer from limited movement of the neck? ☐ Yes ☐ No

Room for any possible questions and/or remarks

Bovenstaande informatie is geschreven samen met artsen en (gespecialiseerd) verpleegkundigen van de genoemde afdeling(en). De afdeling communicatie & patiëntenvoorlichting verzorgt de eindredactie van deze folder.

Heeft u vragen en/of opmerkingen over deze folder? Belt u dan met de genoemde afdeling(en) of stuur een e-mail naar PatiëntService, psb@bernhoven.nl.

Bernhoven

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