

**ÚVN**ÚSTŘEDNÍ VOJENSKÁ NEMOCNICE
Vojenská fakultní nemocnice PrahaU Vojenské nemocnice 1200, IČ: 61383082
Praha 6
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Pre-anesthesia patient questionnaire

**Department of Anesthesiology, Resuscitation and Intensive care medicine
First Faculty of Medicine of Charles University and Central military hospital**

Dear Madam/Sir, your attending physician has recommended surgical or diagnostic procedure requiring anesthesiological care. Information that you will provide below, will help us to choose the most suitable and safest method of anesthesia for you. Please complete this form thoroughly. The information you provide will be confidential and will become part of medical records.

During the pre-anesthetic examination, we will answer any questions and sign an informed consent form together.

Patient Name and Surname: _____ ID number _____

Weight _____ Height _____ Allergies _____

Current medications:

YES	NO	<u>Please fill in the correct answer by ticking YES or NO</u>
[]	[]	Have you had anesthesia in the past?
[]	[]	Have you had any complications during or after anesthesia?
[]	[]	Have you ever been given a blood transfusion?
[]	[]	Do you have loose or otherwise damaged teeth? Dental prostheses?
[]	[]	Do you feel your jaw stiffen while drinking coffee?
[]	[]	Have you recently had the flu, cold, fever, cold sores or other infection?
[]	[]	Do you have chest pain, shortness of breath during exertion, swelling of legs?
[]	[]	Are you in the care of a specialist clinic? (cardio / nephro / pulmonary, etc.)
[]	[]	Do you have heart or vascular disease? (heart attack, hypertension, clots, etc.)
[]	[]	Do you have lung or respiratory diseases? (asthma, bronchitis, etc.)
[]	[]	Do you have diabetes?
[]	[]	Do you have any other diseases? (liver, kidneys, thyroid, nerves, muscles)
[]	[]	Do you have stomach ulcers or other diseases of the stomach or esophagus?
[]	[]	Do you have any problems with your spine?
[]	[]	Do you suffer from increased bruising, bleeding or other blood disorders?
[]	[]	Do you take any painkillers regularly?
[]	[]	Do you smoke (did you smoke)?
[]	[]	Do you drink alcohol regularly?
[]	[]	Do you (did you) use any drugs?

Write important information concerning your health state here (in addition to the questions above):

Please bring this form along with medical report from your general practitioner or internal physician for pre-anesthesia evaluation in our ambulance (building CH1, floor -1). Thank you.

Date _____ Patient signature / Signature of legal representative _____