Health questionnaire

Name:
Date of birth:
Patient number:
Email address:
Mobile number:

Please answer our questions carefully by writing down or ticking the answers where appropriate. It will help us to get a full picture of your health and to adapt the anaesthesia/sedation accordingly.

	Yes	No	Comments
Are you or have you been under control from another specialist?			
Cardiologist			In connection with: Which hospital: Date last visit:
Internist			In connection with: Which hospital: Date last visit:
Neurologist			In connection with: Which hospital: Date last visit:
Pulmonologist			In connection with: Which hospital: Date last visit:
Your length: Your weight::			
Have you previously undergone surgery (anesthesia)?			If so, which operations?
Were there any problems with the narcosis / sedation? • If so, what kind of problems?			
Do you suffer from car sickness?			
Are you allergic or hypersensitive to certain substances? • If yes, which substances?			
Do you smoke? • If so, how many per day?			
Have you been smoking in the past? • If so, how long ago?			
Do you regularly use alcohol? • How many units per week?			
Do you use drugs? • If yes, which one?			
Do you use medication? If so, add a recent medication overview from the pharmacy!			
Is it a problem to fully open your mouth?			

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	Yes	No	Comments
Do you have problems with moving your neck and / or head?			
Do you have a hip replacement?			
• If yes, left or right?			
Do you have joint pain and / or rheumatism?			
Do you regularly suffer from heartburn?			
Have you had (or have had) jaundice and / or liver disease?			
Have you had (or have had) kidney disease?			
Lungs			
Do you have problems with the lungs and / or breathing? • if so, which problems?			
Do you have to cough often? Do you cough chronically?			
Have you been diagnosed with asthma, chronic bronchitis / emphysema or COPD?			
If so, which of the above diseases?			
Are you short of breath if you make an effort? • If so, is this with very little or a lot of effort?			
Do you snore excessively?			
Has you been diagnosed with sleep apnea syndrome (OSAS)? If so, please bring your CPAP device (if you have one)			
Cardiology			
Have you ever had chest pain, a feeling of pressure on the chest? • *If so, does this pain radiate to your arm and / or jaw?*			
Do you ever suffer from palpitations or an irregular heartbeat?			
Have you ever had an EKG made in the last year?			Reason? In which hospital?
Do you become short of breath if you lie flat on the bed?			
Do you have an ICD (internal defibrillator) or a pacemaker?			
Do you have high blood pressure?			
Neurology			
Have you ever had a paralysis?			
Have you ever had a brain haemorrhage or stroke? • If so, when? • Are there any residual symptoms?			

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Have you ever had an insult (epilepsy) or something similar?			
Do you have a disease of the nervous system or the muscles? For instance Parkinson's or muscular dystrophy?			
Diverse			
Do you have diabetes?			
Do you have a thyroid abnormality?			
Do you have glaucoma (increased eye pressure)?			
Do you wear glasses and / or contact lenses?			
Do you have false teeth? • If yes, an upper and / or lower?			
Do you have crowns, inlays or loose teeth?			
Do you use a hearing aid?			
Do you have any bruising, nosebleeds, bleeding wounds long after?			
Have you ever had thrombosis?			
Do you have family members with blood clotting problems?			
Do you have an infectious/contagious disease? • If so, what kind?			
Are you afraid of the operation / treatment and / or sedation / anesthesia?			
For women only:			
Are you pregnant or do you expect to be pregnant?			

Do not forget to also fill in the next page.

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Below is a list of ACTIVITIES. Tick which activities you can carry out regularly (daily or weekly).

	Yes	No
Activities:		
1. Can you eat without help?		
2. Can you dress yourself and go to the toilet?		
3. Can you walk quietly on a flat surface?		
4. Can you carry out light household activities? Like: washing up, preparing the bed?		
5. Can you walk up one flight of stairs or walk slightly uphill?		
6. Can you handle heavier household activities? Such as: cleaning windows and cleaning the bathroom		
7. Do you carry out light leisure activities? Such as: cycling and / or walking.		
8. Do you practice fitness and / or swimming?		
9. Do you take an active part in a sport with a substantial amount physical strain every week? (eg: Tennis / football / rowing etc.)? *Which sport and how many minutes?*		
What causes you to be impeded?		
• Fatigue		
• Poor condition		
• Joint complaints, muscle pain, physical limitations		
• Problems of your heart, chest pain		
• Problems of the lungs, stuffiness		
• A neurological disorder		
• Andere oorzaken Namelijk:		