

MEDICAL QUESTIONS FOR ANAESTHESIOLOGY

name: _____ **Surname :** _____ **birthday:** / /
sexe: M / F **height:** cm **weight:** Kg **B M I =** **Date :** / /

BLOOD

what is your group?: already received blood transfusion?: yes no don't know

ANESTHESY

previous anesthesia?: yes no
local yes no general yes no epidural yes no

problems during this anesthesia ?: yes no
if yes, what happened?:
.....
.....

Have you been hospitalised for a disease?: yes no

if yes, what was the disease,:

list of the medications you take:

aspirin: yes no anticoagulation: yes no
other:

Allergy : yes no

aspirin iode penicillin eczema food cosmetics
 other

Cardio-vascular: yes no

myocardial infarct angina arteritis hypertension phlebitis
 pulmonary embolism tachy-arithmy other:.....

Pulmonary yes no

asthma pneumothorax chronic bronchitis tuberculosis
 other:.....

smoking?: yes no how much?: how long?:

abdomen yes no

gastritis ulcere hepatitis bowel disease
alcohol?: yes no how much?: how long?:

neurological problems yes no

epilepsy spasmophily vasc cerebral accident migraine depression
 discal hernia eye lens yes no dental prosthesis yes no
other:.....

others yes no

diabetes IDDM diabetes NIDDM kidney disease thyroid disease
 eye disease cancer tachy-arithmy other:.....
 details:

.....
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other information:

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