Anästhesiologie
AM BETHANIEN

PD Dr. S. Scholz
Dr. M. Schöffner
Dr. M. Jarrar
T. +49 (0)69 4608 310

Pre-Anaesthesia Patient Questionnaire

To assess your anaesthesia risk, please answer the questions below and bring the completed questionnaire with you to the anaesthesia clinic on the 2nd floor.

Surname, First Name: _____ D.O.B. _____

Height: _____ cm Weight: _____ kg Procedure: _____

Are you under constant medical treatment or have you received medical treatment in the last few weeks?

If **YES,** what for? _____

Do you take medication on a regular basis??
If **YES**, please bring your medication plan with you or list all your medications in the table:

Medication Name	Dose (mg, Units, Puffs…)	Time and Quantity				Since (Date)
		morning	noon	evening	at night	

	NO	YES
Have you ever had an allergic reaction to a medication or substance in the past?	☐	☐
If **YES**, what did you react to and how? _____		
Have you had surgery in the past?	☐	☐
If **YES**, which operations have been performed?_____		
Did complications arise during an operation?	☐	☐
If **YES**, what were the complications? _____		
Have you ever had any problems with an anaesthetic?	☐	☐
If **YES**, which ones? _____		
Do you know anyone in your family who has had problems with anaesthesia?	☐	☐
If **YES**, which ones? _____		

Anästhesiologie
AM BETHANIEN

PD Dr. S. Scholz
Dr. M. Schöffner
Dr. M. Jarrar
T. +49 (0)69 4608 310

	NO	YES
Do you or your blood relatives have a predisposition to high fever during/after anaesthesia (**malignant hyperthermia**)?	☐	☐
Have you received a blood transfusion in the last 3 months?	☐	☐
Did you have any problems following your transfusion?	☐	☐
Can you walk two blocks or **climb two flights** of stairs **without stopping**?	☐	☐
Have you ever **fainted** or passed out for an unclear reason?	☐	☐
Have you had a heart attack or angina (chest pain) in the past? If **yes**, when? _____	☐	☐
Ist bei Ihnen eine Verengung der Herzkranzgefässe (Koronare Herzerkankung) bekannt? Leiden Sie unter Brustschmerzen bei Belastung (Angina pectoris)?	☐	☐
Have you had **coronary stents** implanted? If **yes**, when? _____	☐	☐
Have you had cardiac bypass surgery? If **yes**, when? _____	☐	☐
Have you ever had heart failure?	☐	☐
Do you have a heart murmur, heart valve defect or a congenital malformation of the heart? If **yes**, which one(s)? _____	☐	☐
Has the valve defect/malformation been operated on? If **yes**, when? _____	☐	☐
Do you have an irregular heart beat?	☐	☐
Do you have a **pacemaker** or Implantable Defibrillator (**ICD**)?	☐	☐
Have you ever had a stroke or temporary speech impairment? If **yes**, when? _____	☐	☐
Do you have a known carotid artery stenosis?	☐	☐
Do you have a known narrowing of the vessels in your legs or do you have cramp-like pain when walking for long distances?	☐	☐
Have you had a thrombosis or pulmonary embolism in the past? If **yes**, when? _____	☐	☐
Are you being treated for high blood pressure?	☐	☐
Do you bleed more than normal or has there been a **bleeding complication** during surgery?	☐	☐

	NO	YES
Do you have a known lung disease? If **yes**, which one? _____	☐	☐
Do you use **home oxygen**?	☐	☐
Do you snore at night with breathing pauses or do you suffer from **sleep apnoea**?	☐	☐
Is your sleep apnoea treated with CPAP/BiPAP? If **yes**, bring the device settings with you.	☐	☐
Do you have frequent **heartburn**, ulcers or hiatus hernia?	☐	☐
Have you ever had liver problems? If **yes**, which one(s)? _____	☐	☐
Do you have kidney problems or are you requiring **dialysis**? If **yes**, since when? _____	☐	☐
Do you have diabetes?	☐	☐
Is it type I (**insulin-dependent**) diabetes?	☐	☐
Ist bei Ihnen oder Ihren Blutsverwandten eine angeborene Muskelerkrankung bekannt? Falls **Ja**, welche? _____	☐	☐
Do you have thyroid problems?	☐	☐
Do you have any neurological or psychiatric disease? If **yes**, which one(s)? _____	☐	☐
Have you ever had a seizure? If **yes**, when was the last?_____	☐	☐
Do you have increased intraocular pressure (glaucoma)?	☐	☐
Do you have a spinal or joint disorder? If **yes**, which one(s)? _____	☐	☐
Do you have **dentures**, caps, bridgework, implants or loose teeth?	☐	☐
Do you wear piercings?	☐	☐
Are you pregnant or breast-feeding?	☐	☐
Do you drink alcohol? How many drinks per week? _____	☐	☐
Do you use recreational drugs (e.g. cocaine, ecstasy, crystal meth)? If **yes**, which one(s)? _____	☐	☐
Do you smoke? If **yes**: _____ cigarettes a day over _____ years	☐	☐
Have you had or do you have an **infectious disease** (e.g. hepatitis, HIV/AIDS, tuberculosis)?	☐	☐