

**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:

.....  
.....

other information:

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