ANESTHESIA INTENSIVE CARE

Questionnaire to fill-up before the visit with the anesthetist

Centre Orthopédique Santy – 24 Avenue Paul Santy – F-69008 LYON (2nd Floor)
Tel : +33437530050
Mail : anesthesie.santy@gmail.com

Name: _____ Married Name: _____ Surname: _____

Address: _____ Tel. _____

Profession: _____ Height:_____ cm Weight:_____ kg

Age: _____ year old Birth date: _____ Blood group: _____

Name, address and phone number of the person to contact in case of emergency:

_____

_____

_____

1. Are your vaccinations up to date? (especially tetanus) ❑ Yes – ❑ No

2. Do you smoke? ❑ Yes – ❑ No
If yes, how many cigarettes per day? _____
Since when? _____
Smoking is dangerous for healing ! Please stop smoking 4 weeks before surgery until 4 weeks after !

3. Take you (or have you ever taken) one or several drugs? If yes, which ones? ❑ Yes – ❑ No

4. Do you drink more than half a liter of wine or beer per day? ❑ Yes – ❑ No
How many appetizers per day? _____

5. Are you carrying a hearing aid? ❑ Yes – ❑ No

6. Do you wear contact lenses ❑ Yes – ❑ No

7. Do you wear a brace, artificial teeth: bridge, implants, crown, pivot…? ❑ Yes – ❑ No
If yes, since when? _____

8. Do you have any dental infection problem, or implant infection or fragile teeth ? ❑ Yes – ❑ No

A dental infections contra indicate the surgery
Please take a medical advice with your dentist before the surgery if you have any troubles.

9. Do you have any allergies? ❑ Yes – ❑ No

- ☞ Hives or giant eczema ❑ Yes – ❑ No
- ☞ A severe allergic shock ❑ Yes – ❑ No
- ☞ An angioedema (Quincke disease) ❑ Yes – ❑ No
- ☞ Latex allergy ❑ Yes – ❑ No
- ☞ Iodine injection allergy ❑ Yes – ❑ No
- ☞ Betadine allergy ❑ Yes – ❑ No
- ☞ Food or medicine allergy? ❑ Yes – ❑ No

If yes, which ones? _____

10. Have you recently submitted an infectious condition (dental, urinary or others)? ❑ Yes – ❑ No
Has it been treated? ❑ Yes – ❑ No
How? _____
Are you cured? ❑ Yes – ❑ No

11. Is one member of your entourage suffering from the Creutzfeldt-Jakob disease? ❑ Yes – ❑ No

12. Have you been treated with growth hormones? ❑ Yes – ❑ No

13. Did you have a neurosurgical surgery or a dura mater graft? ❑ Yes – ❑ No

14. Do you take any medicines? herbal treatment ? ❑ Yes – ❑ No
If yes, which ones?_____

15. Have you ever had a general anesthesia? ❑ Yes – ❑ No
If yes, thank you to prepare a list with the surgeries and dates! ❑ Yes – ❑ No
If yes: well tolerated? If no tolerated, why? ❑ Yes – ❑ No
_____

16. Have you ever had a local anesthesia (teeth…)? ❑ Yes – ❑ No

17. Have you ever had a lumbar anesthesia (spinal, epidural)? ❑ Yes – ❑ No

18. Have you ever had a loco-regional anesthesia? ❑ Yes – ❑ No

19. Have you ever had abnormal hemorrhage or bruising? ❑ Yes – ❑ No
(Postoperatively, bleeding, tooth extraction…)
If yes, when and why? _____

20. Do you have a know heart disease? ❑ Yes – ❑ No
If yes, which ones? (tachycardia, palpitations, arrhythmias, myocardial infarction, angina, high blood pressure, heart murmur, heart failure, Pace Maker, Implantable defibrillator, arteries, carotid arteries…)
Thank you to notify the name, address, phone number, email address of the cardiologist in charge of you: _____
_____
_____

21. Do you have varicose veins or venous insufficiency? ❑ Yes – ❑ No
Have you ever had phlebitis? ❑ Yes – ❑ No
Have you ever had a pulmonary embolism? ❑ Yes – ❑ No
If yes, under what circumstances?_____

22. Have you ever had a respiratory disease? ❑ Yes – ❑ No
If yes, which ones? _____
(cough, breathlessness, asthma, bronchitis, tuberculosis, cancer)

23. Have you ever had digestive problems? ❑ Yes – ❑ No
☞ gastritis, ulcer of stomach or duodenum, hiatal hernia? ❑ Yes – ❑ No
☞ colon disease? ❑ Yes – ❑ No
☞ liver disease (cirrhoses, jaundice, hepatitis A, B, C) ❑ Yes – ❑ No
☞ pancreatic disease? ❑ Yes – ❑ No

☞ Other intestinal diseases (Crohn's disease, ulcerative colitis) ❑ Yes – ❑ No

24. Have you ever had a kidney or urinary tract disease? ❑ Yes – ❑ No
(urinary infection, renal colic, renal failure…)

25. Ladies, do you have children? ❑ Yes – ❑ No
If yes, how? _____
☞ Are you pregnant? ❑ Yes – ❑ No
If yes, how long? _____
☞ Did you have obstetrical disease during pregnancy? ❑ Yes – ❑ No
☞ Did you have miscarriage? ❑ Yes – ❑ No
If yes, how? _____
☞ Do you have gynecological problem? ❑ Yes – ❑ No
If yes, which ones: _____

26. Are you diabetic? ❑ Yes – ❑ No
If yes, with complication? _____

27. Do you have thyroid problems? ❑ Yes – ❑ No

28. Do you have too much cholesterol, triglycerides, uric acid (gout)? ❑ Yes – ❑ No

29. Do you have eyes disease? ❑ Yes – ❑ No
If yes, which ones? _____
(glaucoma, cataract, high myopia, retinal detachment, corneal transplant, single eye…)

30. Do you or did you have a neurological disease? ❑ Yes – ❑ No
If yes, which ones? _____
(cranial trauma, meningitis, convulsions, migraines, surgery…)

31. Are there any serious medical histories in your family? ❑ Yes – ❑ No
(cancer, cardiac disease, genetic or hereditary disease, anesthetic accident, hemophilia, myasthenia, malignant hyperthermia, porphyria…)

32. Do you have any remarks to make concerning your health? ❑ Yes – ❑ No
_____
_____
_____
_____

33. Authorization for AIDS screening test

❑ Yes – ❑ No

I undersigned: (your name and surname) _____
allow Hôpital Privé Jean Mermoz to perform a screening test to detect the presence of the AIDS in my preoperative blood tests.

34. Authorization for blood transfusion

❑ Yes – ❑ No

I undersigned: (your name and surname) _____
allow Hôpital Privé Jean Mermoz's physicians to perform, if necessary and after being informed, a blood transfusion or stable blood derivatives.

Date: _____

Signature: _____
Parental signature required for minor children (under the age of 18 year old)