

# ANESTHESIA INTENSIVE CARE

## Questionnaire to fill-up before the visit with the anesthetist

Centre Orthopédique Santy – 24 Avenue Paul Santy – F-69008 LYON (2<sup>nd</sup> 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

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- 11.** Is one member of your entourage suffering from the Creutzfeldt-Jakob disease?  Yes –  No
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- 12.** Have you been treated with growth hormones?  Yes –  No
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- 13.** Did you have a neurosurgical surgery or a dura mater graft?  Yes –  No
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- 14.** Do you take any medicines? herbal treatment ?  Yes –  No  
If yes, which ones? \_\_\_\_\_
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- 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  
\_\_\_\_\_
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- 16.** Have you ever had a local anesthesia (teeth...)?  Yes –  No
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- 17.** Have you ever had a lumbar anesthesia (spinal, epidural)?  Yes –  No
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- 18.** Have you ever had a loco-regional anesthesia?  Yes –  No
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- 19.** Have you ever had abnormal hemorrhage or bruising?  Yes –  No  
(Postoperatively, bleeding, tooth extraction...)  
If yes, when and why? \_\_\_\_\_
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- 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? \_\_\_\_\_
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- 22.** Have you ever had a respiratory disease?  Yes –  No  
If yes, which ones? \_\_\_\_\_  
(cough, breathlessness, asthma, bronchitis, tuberculosis, cancer)
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- 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 (cirrroses, jaundice, hepatitis A, B, C)  Yes –  No  
☞ pancreatic disease?  Yes –  No
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Other intestinal diseases (Crohn's disease, ulcerative colitis)  Yes –  No

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

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**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: \_\_\_\_\_

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**26.** Are you diabetic?  Yes –  No

If yes, with complication? \_\_\_\_\_

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

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

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**29.** Do you have eyes disease?  Yes –  No

If yes, which ones? \_\_\_\_\_

(glaucoma, cataract, high myopia, retinal detachment, corneal transplant, single eye...)

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**30.** Do you or did you have a neurological disease?  Yes –  No

If yes, which ones? \_\_\_\_\_

(cranial trauma, meningitis, convulsions, migraines, surgery...)

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**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...)

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**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.

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**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.

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**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

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