Information about patient's health

All the data provided is covered by medical secrecy and is only used to take care of patient's safety. Please answer the questions carefully. If you have any problems with answering to a question, please skip this particular one, and clarify your doubts with the doctor. All the questions in the survey are used to collect the data needed to provide the best treatment possible, and to choose a suitable anesthesia.

Name:…… Surname:……...

Date of birth:……. Personal identity:……..

Address:……

Weight:……kg Growth:……..cm

Please choose the correct answer:

1. Are you feeling healthy? YES / NO
2. Have you been in the hospital within last 2 year? YES / NO
   If yes, what was the reason……
3. Are you being treated of some disease? YES / NO
4. Are you taking some medicines (especially aspirin, anticoagulants, or others) YES / NO
   If yes, what kind?.....
5. Do you have any allergies? YES / NO
   If yes, what allergies?.....
6. Do you have:

shortness of breath	YES / NO	swelling	YES / NO
hives	YES / NO	itch	YES / NO

7. Do you have a tendency to bleed? YES / NO
8. Did you have episodes of consciousness loss, or fainting? YES / NO
9. Do you have a pacemaker? YES / NO
10. Did you have any of the following diseases?
    a. heart disease (myocardial infarction, coronary artery disease, heart failure, arrhythmia, myocarditis, or other) YES / NO
    b. other cardiovascular diseases (hypertension, low blood pressure, fainting, shortness of breath, or other YES / NO
    c. vascular disease (varicose veins, phlebitis, poor blood supply to the extremities, leg pain when walking or other) YES / NO
    d. pulmonary disease (emphysema, pneumonia, tuberculosis, asthma, chronic bronchitis or other) YES / NO

e. gastrointestinal disease (stomach ulcers, duodenal ulcers, intestinal diseases or other) YES / NO
f. liver disease (cholelithiasis, jaundice, cirrhosis of the liver or other) YES / NO
g. urinary tract disease (nephritis, kidney stones, difficulty passing urine, or other) YES / NO
h. metabolic disorders (diabetes, gout or other) YES / NO
i. thyroid disease (hyperthyroidism, hypothyroidism, goiter, or other inert) YES / NO
j. diseases of the nervous system (epilepsy, paresis, loss of consciousness, paralysis, sensory disturbances, myasthenia gravis or other) YES / NO
k. diseases of the bone and joint pain (pain roots, degenerative changes of the spine, joints, conditions after fractures or other) YES / NO
l. blood disorders and coagulation (hemophilia, anemia, prone to flooding bloody, epistaxis, prolonged bleeding after tooth extraction or other) YES / NO
m. eye diseases (glaucoma, vision defect or other) YES / NO
n. changes in mood (depression, neurosis) YES / NO
o. the communicable diseases YES / NO

viral hepatitis A	YES / NO	AIDS	YES / NO
viral hepatitis B	YES / NO	tuberculosis	YES / NO
viral hepatitis C	YES / NO	Venereal	YES / NO

1. rheumatic disease YES / NO
2. osteoporosis YES / NO
3. other diseases, what? ……..

11. Have you been treated in other health care facilities within last 6 months? YES / NO
When, where? …….
12. Did you have any of the following procedures within last 6 months (injections, blood collection, injections, biopsies, punctures, acupuncture, allergy tests)? YES / NO
If yes, when and where?.....
13. Did you use cosmetic services within last 6 months? YES / NO
When where? …….
14. Do you have a tattoo? YES / NO
15. Have you been vaccinated against hepatitis? YES / NO
Where?..... .....
When ?: I dose: ..... II dose: ..... III dose: .....
16. Within last two months did you have contact with a person with hepatitis? YES / NO
When where? …….
17. What was the last blood pressure measurement ……
18. Have you ever had a surgery? YES / NO
If yes, what was the reason?.....
19. Do you tolerate anesthesia well? YES / NO
20. Do you smoke cigarettes? YES / NO
If yes, how many per day?.....
21. Do you drink alcohol? NO / SOMETIMES / OFTEN

22. Are you taking sedatives, hypnotics, narcotics? YES / NO
    If so, which:……..

Question to women only:

23. Are you pregnant? YES / NO
    If yes, which months is it: ……
24. When did you have your last menstruation? ……...
25. Do you use oral contraceptives? YES / NO

Patient's, legal guardian's, or parent's statement

I declare that I have answered all the questions carefully and truthfully. All the changes in my health will be reported during the next doctor visit.

…… ……

Date and patient's signature(or legal guardian's , parent's signature) Signature of a patient between 16-18yo