Preoperative survey
Anaesthetics Department

GZA
Ziekenhuizen
GasthuisZusters Antwerpen
Sint-Augustinus - Sint-Vincentius - Sint-Jozef

Name : ..... First name: .....

Date of birth: ...../...../.....

Surgical intervention/examination:..... left ☐ right ☐

Physician: .....

Date of hospitalisation: ...../...../..... Time:..... Date of surgery: ...../...../.....

Weight: ..... kg Length:..... cm Blood type: ..... Please bring your blood type card

Contact person: Name: ..... Telephone: .....

Name: ..... Telephone: .....

1. Do you have **allergies**? Indicate what reaction you had: swelling, shortness of breath, itching, redness

- Latex yes ☐ no ☐ reaction: .....
- Contrast substances yes ☐ no ☐ reaction: .....
- Bandages yes ☐ no ☐ reaction: .....
- Medication ..... reaction: .....
- Other ..... reaction: .....

e.g. dyes, kiwi, bananas, hay fever, food products

2. Do you smoke? yes ☐ no ☐ how much? ..... per day

Have you ever smoked? yes ☐ no ☐ for how long? ..... years, until .....

Do you drink alcohol? yes ☐ no ☐ how much: ..... glasses per ☐ day ☐ week

Do you use drugs? yes ☐ no ☐ which? .....

3. Do you have...

Dentures? yes ☐ no ☐

Artificial teeth? yes ☐ no ☐

Loose teeth? yes ☐ no ☐ which? .....

Contact lenses? yes ☐ no ☐

A hearing aid? yes ☐ no ☐ left ☐ right ☐

Piercings? yes ☐ no ☐ If so, please remove them at home.

Artificial nails? yes ☐ no ☐ If so, please remove them at home.

A pacemaker, ICD, stimulator, implanted pump? yes ☐ no ☐

4. Did you have any **surgery in the past**? yes ☐ no ☐

If so, in which year and which surgery:

In ..... For: .....

In ..... For: .....

In ..... For: .....

In ..... For: .....

Did you react in an unusual manner to any previous anaesthesia? yes ☐ no ☐

If so, specify as accurately as possible: .....

Did any family member ever have any problems with anaesthesia? yes ☐ no ☐

If so, specify as accurately as possible: .....

5. Are you being monitored by a **specialist** in another hospital (for heart/lungs/…)

If so, what for, in which hospital, by which doctor:

For: ..... Hospital: ..... Doctor: .....

For: ..... Hospital: ..... Doctor: .....

For: ..... Hospital: ..... Doctor: .....

6. Do you have high blood pressure? yes ☐ no ☐

Are you quickly **out of breath?** yes ☐ no ☐

Do you have any problems while doing domestic work? yes ☐ no ☐

Can you do **two flights of stairs** without stopping? yes ☐ no ☐

Do you sometimes have swollen feet? yes ☐ no ☐

Do you sleep in a half-seated position yes ☐ no ☐

Do you suffer from **palpitations**? yes ☐ no ☐

Do you sometimes have a **constrictive feeling** in your arm or chest? yes ☐ no ☐

Did you ever suffer from repeated **fainting**? yes ☐ no ☐

Are you being treated for a **heart disease**? yes ☐ no ☐

Did you ever suffer from phlebitis or thrombosis? yes ☐ no ☐

Do you easily have nose bleeds or bruises? yes ☐ no ☐

Are you taking **blood thinning medication**? yes ☐ no ☐

If your GP or attending physician did not give you any instructions on their use relating to your surgery, please contact the anaesthetics department

7. Do you wheeze when breathing? yes ☐ no ☐

Are or were you being treated for a **lung disease?** yes ☐ no ☐

8. Are you a kidney dialysis patient? yes ☐ no ☐

Are or were you being treated for a kidney disease? yes ☐ no ☐

which: .....

9. Are you **diabetic?** yes ☐ no ☐

Are you taking: injections oral medication

10. Did you ever have a stomach ulcer or stomach bleeds? yes ☐ no ☐

Are you suffering from heartburn? yes ☐ no ☐

Did you ever have jaundice (type: .....) yes ☐ no ☐

11. Are you suffering from epilepsy? yes ☐ no ☐

Have you ever been treated by a neurologist or a psychiatrist? yes ☐ no ☐

Are you suffering from tingling or numbness? yes ☐ no ☐

where:.....

Do you suffer from confusion or memory impairment? yes ☐ no ☐

12. Do you **have difficulties opening your mouth?** yes ☐ no ☐

for this, put at least 2 superimposed fingers in the mouth opening

Do you have difficulties moving your head? yes ☐ no ☐

Do you have rheumatism or arthritis? yes ☐ no ☐

Do you have a shoulder, knee or hip prosthesis? yes ☐ no ☐

If so, on which side? le ☐ ri ☐

13. Are you (potentially) pregnant? yes ☐ no ☐

Are you breast-feeding? yes ☐ no ☐

14. Do you have an infectious disease? yes ☐ no ☐

which: .....

15. Have you ever had a blood transfusion? yes ☐ no ☐

reason: ..... unusual reaction yes ☐ no ☐

Do you give **your permission to administer blood products** if needed: yes ☐ no ☐

Do you have any additional comments:.....

.....

.....

☐ **I was adequately informed about the anaesthesia and the possible risks, side effects and alternatives by means of the information brochure, the website (www.anesthesie-augustinus.be), the surgeon and / or anaesthetist, and I consent.**

☐ **I consent that the type of anaesthesia and / or analgesia may be changed during surgery without my knowledge if need be.**

☐ **I consent that my data be anonymously processed for scientific research.**

DIRECTIVES FOR AN EMPTY STOMACH. You may consume what follows:	
up to 6 hours before surgery	Light solid food, full liquids (milk, soup, fruit juice, soda water ...), formula for babies > 3 months
up to 4 hours before surgery	breast-feeding, formula for babies < 3 months
up to 2 hours before surgery	clear liquids: water, coffee or tea **without milk**, clear apple juice without pulp; **maximum 1 glass**
up to 1 hours before surgery	medication with a mouthful of water

These directives must be respected in case of general narcosis or loco-regional anaesthesia; failing to observe these directives may endanger your life and will lead to postponement of the surgery.

MEDICATION

Also think of inhalers, patches, eye drops...

Medication	Dose as listed on the packaging	Empty stomach	Breakfast	Noon	Evening	Bedtime	Notes: e.g. - end date - As needed - Mon-Wed-Fri
EXAMPLE: Product X	**250 mg**	**1**		**½**		**1**	**Mon and Thu**

Name + Signature (mandatory for parent / guardian of an underage patient): .....

.....

Date: ...../...../.....

Social survey

- **Living situation** ☐ at home ☐ supportive housing ☐ nursing home ☐ service flat ☐ other .....
- **Do you get help at home:**

	who?	telephone	what for?	how frequently?
Family/friends/volunteer aid				
Professional care				
Professional care				
Others				
Others				

- **Fall prevention:** Have you fallen the last 6 months? ☐ yes ☐ no
  Are you presently in hospital due to a fall incident? ☐ yes ☐ no
- **Risk of delirium:**
  - Have you ever had periods of confusion? ☐ yes ☐ no
  - Do you have a metabolic disorder (diabetes, thyroid)? ☐ yes ☐ no
  - Cognitive impairment (stroke, dementia, Parkinson's, concussion, brain tumour)? ☐ yes ☐ no
  - Are you hard of hearing? ☐ yes ☐ no
    visually impaired? ☐ yes ☐ no
- **Medication self care:** ☐ autonomous ☐ supervised ☐ impossible
- **Are you autonomous for:**

Washing	☐ yes	☐ often	☐ occasionally	☐ no
Getting dressed / undressed	☐ yes	☐ often	☐ occasionally	☐ no
Getting around indoors	☐ yes	☐ often	☐ occasionally	☐ no
Toilet visits	☐ yes	☐ often	☐ occasionally	☐ no
Eating and drinking	☐ yes	☐ often	☐ occasionally	☐ no

- **Do you suffer from loss off:**

Urine	☐ yes	☐ often	☐ occasionally	☐ no
Faeces	☐ yes	☐ often	☐ occasionally	☐ no

- **Religion:** ☐ I am religious and / or I follow a particular philosophy of life: .....
  ☐ I am not religious or prefer not to mention it
- **Food:**
  - Are you over-sensitive to certain food products? If so, to which: .....
  - Have you lost weight the last 6 months? ☐ yes ..... kg ☐ no
  - Do you have any feeding problems (difficulty swallowing, loss of appetite...)? ☐ yes ☐ no
  - Are you on a diet: specify .....
- **Education**
  - I need additional information. Specify .....

Is there anything else you wish to mention? .....

.....

This form was filled out on ...../...../..... (dd/mm/yyyy) by .....

☐ patient ☐ family (relationship) ..... ☐ other .....