Sint-Maarten
algemeen ziekenhuis
emmaüs

identification sticker

Anesthesia

dr. Batens - dr. Beckers - dr. De Medts
dr. De Sommer - dr. Drijvers - dr. Lemmens
dr. Liesmons - dr. Malcorps - dr. Mariën
dr. Mattheussen - dr. Moens - dr. Nobels
dr. Notelé - dr. Pauwels - dr. Stevens - dr. Stessel
dr. Vanderstappen - dr. Verplaetse - dr. Wets

Surgeon: ..... Date : ..... - ..... - .....

Proposed Surgery : .....

On which side of your body: ❑ Left ❑ Right

Anesthetic Questionnaire

Please bring this form when admitted.

In order to guarantee a smooth, safe and personal anesthesia, please fill out this questionnaire as accurately as possible. We will handle this information most confidentially.

Date of birth: .....
Height: ..... Weight: .....
Profession: .....
Address + home phone or cellphone: .....
.....

Religion: .....
Contact person: .....
telephone number: .....
General practitioner: .....
Blood Type: .....

Check the correct answers in the boxes below. Check the question mark when you don't know the answer or explain in a few words.

Have you had surgery before? Which procedures?	❑ no	❑ yes	❑ ?	.....
Did you experience any problems with anaesthetics in the past. e.g. vomiting	❑ no	❑ yes	❑ ?	.....
Has anyone related to you had a major complication that was related to receiving anesthesia?	❑ no	❑ yes	❑ ?	.....
Have you ever received a blood transfusion?	❑ no	❑ yes	❑ ?	.....
Are we allowed to give you a blood transfusion if needed?	❑ no	❑ yes	❑ ?	if not, why: .....
Do you have false, pivot or loose teeth?	❑ no	❑ yes	❑ ?	.....
Do you use cannabis, cocaine, marihuana, amphetamines?	❑ no	❑ yes	❑ ?	.....
Are you currently pregnant?	❑ no	❑ yes	❑ ?	.....
Do you sometimes perform heavy labour?	❑ no	❑ yes	❑ ?	.....
When doing physical exercise, do you easily feel short of breath?	❑ no	❑ yes	❑ ?	.....
Do you have asthma?	❑ no	❑ yes	❑ ?	.....
Are you short of breath at night or when lying down?	❑ no	❑ yes	❑ ?	.....
Do you sometimes suffer from swollen feet or legs?	❑ no	❑ yes	❑ ?	.....
Do you sometimes feel heaviness in the chest?	❑ no	❑ yes	❑ ?	.....
Did you ever have a heart attack, do you have a heart murmur or heart disease?	❑ no	❑ yes	❑ ?	.....
Have you ever had low blood pressure?	❑ no	❑ yes	❑ ?	.....
Have you ever had phlebitis?	❑ no	❑ yes	❑ ?	.....
Do you drink alcohol (wine, beer) regularly?	❑ no	❑ yes	❑ ?	.....

Do you take sedatives or sleeping tablets?	❑ no	❑ yes	❑ ?	.....
Are you on a diet?	❑ no	❑ yes	❑ ?	.....
Do you smoke? Did you ever smoke? How much?	❑ no	❑ yes	❑ ?	.....
Have you recently had a cold or the flu?	❑ no	❑ yes	❑ ?	.....
Do you cough? Do you have a wheezing breath?	❑ no	❑ yes	❑ ?	.....
Do you cough up?	❑ no	❑ yes	❑ ?	.....
Have you ever been admitted to hospital for bronchitis, pneumonia or other lung related illnesses?	❑ no	❑ yes	❑ ?	.....
Have you ever had hepatitis?	❑ no	❑ yes	❑ ?	.....
Are you being treated for diabetes?	❑ no	❑ yes	❑ ?	.....
Are you allergic to:	❑ no	❑ yes	❑ ?	.....
Certain foods (ex. Kiwi, banana,…)	❑ no	❑ yes	❑ ?	.....
Medication, antibiotics	❑ no	❑ yes	❑ ?	.....
Mites, pollen	❑ no	❑ yes	❑ ?	.....
Latex, rubber products	❑ no	❑ yes	❑ ?	.....
Elastoplast, disinfectants	❑ no	❑ yes	❑ ?	.....
Do your kidneys function less efficiently then normal? Do you have urinary problems?	❑ no	❑ yes	❑ ?	.....
Have you ever had an ulcer?	❑ no	❑ yes	❑ ?	.....
Do wounds bleed long?	❑ no	❑ yes	❑ ?	.....
Have you ever had seizures with loss of conscience, with or without epilepsy, muscle twitches?	❑ no	❑ yes	❑ ?	.....
Do you have a numb or paralysed arm or leg?	❑ no	❑ yes	❑ ?	.....
Do you suffer from any eye-illnesses?	❑ no	❑ yes	❑ ?	.....
Do you suffer from loss of hearing?	❑ no	❑ yes	❑ ?	.....
Are you being treated for a nervous disease?	❑ no	❑ yes	❑ ?	.....
Is there anything else you would like to mention?	❑ no	❑ yes	❑ ?	.....
.....				
Do you take medication on a regular basis? If so, please fill out the medication list attached.	❑ no	❑ yes	❑ ?	.....
Do you frequently experience pain? If yes, please fill out the attached pain questionnaire.	❑ no	❑ yes	❑ ?	.....

I ....., give my consent to the physician-anaesthesiologist for the administration of anaesthesia during my procedure. I declare having been informed sufficiently about the general anaesthesia and/ or locoregional/ epidural analgesia that will be administered. I am aware of the possible side effects and/ or complications as discussed in the information brochures.

Date: ..... - ..... - ..... Signature:

For minors: parent or guardian.

Important remarks:

- Be sober in case of procedure under anaesthetic: do not eat or drink 6h before the procedure is planned.
- Do not smoke 24h before the procedure is planned.
- Take off false teeth, piercings (especially in mouth and nose wings), glasses, hearing aid, earrings, hairpins,… 1h before the procedure is planned.

More info: www.azsintmaarten.be/anesthesie

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My medication schedule

Ask help from a caregiver (general practitioner, pharmacist, nurse...)

Name: ..... Filled out on:: ..... / ..... / .....

.....

❑ I don't take any medication.

If possible, bring your medicines into hospital

NAME OF THE MEDICINE	Dose (e.g. number of milligrams)	Number					Write down here -Daily, weekly, monthly, if necessary -Possibly stopping date -Remarks
		Sober	Breakfast	Noon	Evening	Bedtime	

Check whether your medication schedule is complete using the list below: haven't you forgotten about any of the following?					
❑ Blood thinners	❑ Eye/ear/nose drops	❑ Sleeping pills	❑ Hormonal preparations	❑ Recent use of antibiotics (less than 3 months ago)	❑ Inhalers
❑ Something against stomach aches	❑ Pain killers	❑ Transdermal patches	❑ Non-prescribed medication	❑ Ginkgo biloba ,St. John's wort or other herbal preparations	❑ Syringes

Continuation – if necessary

NAME OF THE MEDICINE	Dose (e.g. number of milligrams)	Number					Write down here -Daily, weekly, monthly, if necessary -Possibly stopping date -Remarks
		Sober	Breakfast	Noon	Evening	Bedtime	

Pain questionnaire

		no	yes
1	Do you already experience pain in the operating area?	❑	❑
2	Do you already experience other pains (e.g. chonic headache, backpain, …)?	❑	❑
3	Have you been verry stressed out or overloaded in the past six months?	❑	❑
4	Do you suffer from at least two or more of the following symptoms? Insomnia, fatigue, anxious thoughts, vertigo, a feeling of being misunderstood, a need for sleeping pills or tranquilizers.	❑	❑