Medical questionnaire

ENDOTERAPIA

Surname and forename ..... Date .....

Date of birth ..... height ..... weight .....

Residence address .....

.....

Contact telephone .....

Please complete this questionnaire. Please mark the selected answer. If any question is difficult for you or certain phrases are unclear (embarrassing), you may consult your doctor before the examination.
The questionnaire is intended only for medical purposes.

Planned endoscopic procedure:

Gastroscopy ☐ **Colonoscopy** ☐

MARK THE CORRECT ANSWER WITH A CROSS

1. Do you take any medicines:

yes ☐ name, dose, since when? no ☐

.....

.....

.....

.....

2. Have you been operated upon, and when and for what reason ?

yes ☐ please specify no ☐

.....

.....

.....

3. Were any particular reactions observed during anaesthesia?

yes ☐ please specify no ☐

.....

.....

4. Heart disorders: have you had myocardial infarction, myocarditis, do you have a heart defect, cardiac arrhythmia, other?

yes ☐ please specify no ☐

.....

.....

5. Cardiovascular disorders: do you have arterial hypertension, vascular disorders?

yes ☐ please specify no ☐

.....

.....

6. Vascular disorders: have you had superficial phlebitis, deep phlebitis, do you have pain in calves?

yes ☐ please specify no ☐

.....

7. Respiratory disorders: do you have asthma, chronic bronchitis, emphysema, pneumoconiosis, pneumonia, tuberculosis?

yes ☐ please specify no ☐

.....

8. Liver disorders: have you had viral hepatitis, jaundice, do you have liver cirrhosis?

yes ☐ please specify no ☐

.....

9. Kidney disorders: have you had kidney stones, nephritis, urinary tract infections?

yes ☐ please specify no ☐

.....

10. Endocrine disorders: have you had pituitary, thyroid, parathyroid, adrenal, other disorders?

yes ☐ please specify no ☐

.....

11. Metabolic disorders: do you have diabetes, gout, other?

yes ☐ please specify no ☐

.....

.....

12. Eye disorders: do you have glaucoma, cataract, sight defect?

yes ☐ please specify no ☐

.....

13. Neurologic disorders: do you have epilepsy, have you had a stroke, do you have paresis, paralysis of lower limbs, arms, hemiparesis, myasthenia, multiple sclerosis, other?

yes ☐ please specify no ☐

.....

.....

14. Blood and coagulation system disorders: do you have haemophilia, other hematologic disorders ? Do you have an increased bruising or bleeding tendency?

yes ☐ please specify no ☐

.....

.....

15. Allergies: are you allergic to medicines (please give the drug name), foodstuffs, disinfectants, contrast agents, other?

yes ☐ please specify no ☐

.....

.....

16. Has anybody in your family had muscular disorders, malignant hyperthermia due to anaesthesia ?

yes ☐ please specify no ☐

.....

.....

17. Stimulants or sedative drugs

yes ☐ tobacco no ☐

yes ☐ alcohol no ☐

yes ☐ other stimulants no ☐

yes ☐ Sedative drugs and tranquilizers: name, dose, since when? no ☐

.....

18. Dentition: do you have dentures, loose teeth?

yes ☐ no ☐

19. Are you pregnant?

yes ☐ no ☐

20. Are you breast-feeding?

yes ☐ no ☐

21. Have you had viral hepatitis (infectious jaundice type A, B, C, other)?

yes ☐ please specify: no ☐

.....

.....

22. Have you had hepatitis markers (e.g. HBs, HCV) detected at any time?

yes ☐ please specify: no ☐

.....

23. Have you been vaccinated against viral hepatitis?

yes ☐ when? no ☐

24. Have you been found infected with HIV ?

yes ☐ no ☐

.....

25. Have you ever received a transfusion of blood or blood products?

yes ☐ when? no ☐

.....

26. Were you treated in another hospital in the past 6 months?

yes ☐ when? no ☐

.....

27. In the past 6 months, did you undergo acupuncture, any dental, cosmetic (e.g. tattoo, piercing) or other procedures during which you could have been cut (e.g. performed by a hairdresser)?

yes ☐ please specify: no ☐

.....

Main gastrointestinal complaints:

mark your answer with a cross

Abdominal pain	yes		no	
Weight loss	yes		no	
Presence of blood in faeces	yes		no	
Constipation	yes		no	
Diarrhoea	yes		no	
Nausea, vomiting	yes		no	
Bloating	yes		no	
Heartburn	yes		no	
Fever	yes		no	
Jaundice	yes		no	
Skin itching	yes		no	
Discoloration of urine and faeces	yes		no	
Presence of complaints during the night	yes		no	

I hereby agree for the proposed form of anaesthesia in intravenous sedation.

INFORMATION FOR THE PATIENTS WHO UNDERWENT THE PROCEDURE UNDER ANAESTHESIA

AFTER THE PROCEDURE UNDER ANAESTHESIA YOU MUST RETURN HOME WITH A RESPONSIBLE ADULT CAPABLE PERSON

ASA	I	II	III	IV

....

Date and signature of patient ***Signature of anaesthesiologist***

WITHIN 12 HOURS AFTER ANAESTHESIA, YOU ARE PROHIBITED TO:

- ✓ **Drive a car or other vehicles**
- ✓ **Operate complex devices and machines**
- ✓ **Drink alcohol**
- ✓ **Take important personal or work-related decisions**
- ✓ **Perform other activities requiring normal psychomotor performance**