CHIROPLASTICA
Dolnośląskie Centrum Chirurgii Ręki i Medycyny Estetycznej

PREOPERATIVE ANESTHETIC SURVEY

The role of anesthesiologist is to ensure the greatest safety and comfort for the Patient during operations and procedures. Anesthesiologist's main care is to relieve pain by giving pain-killing medications or applying general anesthesia to Patients.

Some procedures may be carried out in local anesthesia, including just a specified part of the body. Such anesthesia is only a small burden for the body. Contrary to some patients' concerns, local anesthesia into spine area (spinal epidural) very seldom leads to nerve damage. Anesthesiologist monitors organism's actions during the procedure and immediately handles any complications that might occur.

Preoperational survey is aimed at obtaining information based on which it shall be possible to select the most advantageous anesthetic approach. Your cooperation shall add to optimal anesthesia application. Please kindly reply to questions below, and during conversation with an anesthesiologist, feel free to ask further questions and **be sure to sign anesthesia consent only in his/her presence.**

NAME & LAST NAME	TELEPHONE NO.	AGE	WEIGHT	HEIGHT

OPERATION DATE	TYPE OF THE PLANNED OPERATION	SURGEON LAST NAME & CLINIC ADDRESS:
		Dr.: …….. CHIROPLASTICA 36A, Dabrowskiego Street, 1-2 U 50457 Wroclaw, Poland

Please underline or circle the right answer: "YES/ NO/ I DON'T KNOW"

When saying YES, please underline or circle name of the illness mentioned in brackets, or give a detailed answer:

- Are you currently under treatment of some illnesses? YES/ NO/ I DON'T KNOW
  If so, what illness?.....
- What medications do you take?.....
- Have you ever been subject to operation? YES/ NO/ I DON'T KNOW
  If so, what operations, and in what year?.....

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- Have you tolerated anesthesia(s) well? YES/ NO/ I DON'T KNOW
- Have you had blood transfusions? YES/ NO/ I DON'T KNOW
- When?
- Have there been any complications related to blood transfusion? YES/ NO/ I DON'T KNOW

Have you suffered from the following diseases:

-heart diseases (ischemia, myocardial infarction, arrhythmias, heart defect)
YES/ NO/ I DON'T KNOW

-cardiovascular disease (high blood pressure, low blood pressure, shortness of breath, rapid fatigue)
YES/ NO/ I DON'T KNOW

- vascular disease (atherosclerosis, varicose veins, pain in the calves when walking, cold legs, calf cramps, poor blood supply to the limbs, phlebitis) YES/ NO/ I DON'T KNOW

- Lungs diseases (pneumonia, tuberculosis, emphysema, pneumocosis, asthma, obstructive lung disease) YES/ NO/ I DON'T KNOW

- ulcers of the stomach or duodenum, heartburn, gastritis, pancreatic, jaundice, gall bladder illness, hepatitis YES/ NO/ I DON'T KNOW

- kidney disease (nephritis, kidney stones, difficulty in urinating) YES/ NO/ I DON'T KNOW

- diabetis, gout, poryphyria YES/ NO/ I DON'T KNOW

- thyroid diseases (hyperthyroidism, hypothyroidism, neutral goiter YES/ NO/ I DON'T KNOW

- glancoma YES/ NO/ I DON'T KNOW

- celebral apoplexy, loss of consciousness, seizures, epilepsy, nerve palsies YES/ NO/ I DON'T KNOW

-Depression, neurosis YES/ NO/ I DON'T KNOW

-Problems related to spine, bones, joints YES/ NO/ I DON'T KNOW

If so, what are these illnesses?.....

- Muscle diseases YES/ NO/ I DON'T KNOW
- Do you suffer from longer blood coagulation process when cuts occur? YES/ NO/ I DON'T KNOW
- Do you have tendency to bruises? YES/ NO/ I DON'T KNOW
- Do you suffer from allergies (hay fever, shortness of breath, rash, allergy to: patch, iodine, medicines, soy, egg white protein) YES/ NO/ I DON'T KNOW
  If so, to what?.....
- When was the last time you had a cold, pharyngitis, laryngitis, bronchitis?
- If you suffer from diseases not mentioned above, please specify what they are:
  .....
  .....
- Do you have intensive gagging? YES/NO
- Do you use dentures? YES/NO
- Are you wearing earrings (not in ears, but elsewhere) YES/NO

  If so, where?.....
- Do you smoke cigarettes? YES/NO

  If so, how many?.....

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- Do you drink on a regular a basis? YES/NO
- Do you take sedatives or sleeping medicines? YES/NO
  If so, what are they?.....
- Do you take any drugs YES/NO

- Are you pregnant? YES/ NO/ I DON'T KNOW
- When was your last menstruation?.....
- Did you give birth to children? .... Yes/ No/ I do not know

  IF YES:
- What are the dates of the childbirth(s)? ....

  - Was the childbirth natural, or by Caesarean section? .....
  - Did you have any complications? .... YES/ NO/ I do not know

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Patient's statement

Dr ..... has talked to me and explained in detail the issue of anesthesia for operation purpose. During this conversation I could ask about all anesthesia problems that seemed interesting to me, including the risk and other perioperative circumstances. I have understood everything clearly, I have no further questions thereto and so I agree to anesthesia and the related procedure before-, during and after the operation. I agree to justified medical changes in anesthetic proceedings, including change of anesthesia type.

I declare that I shall not eat any foods within the 6 hours prior to surgery, and I shall not take any liquids during 2 hours prior to surgery.

I declare that within 24 hours after surgery I shall not drive a car or operate any mechanical equipment. I shall go home in the company of an adult guardian.

On the day of surgery I shall not apply any face cream.

.....	.....
Doctor signature	**Patient signature** (in the presence of the doctor)

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EPIDEMIOLOGICAL INTERVIEW

(concerns the Patient's past in the last 6 months prior to admission to the Clinic)

Surname and name ....

Date of birth .....

Height .....

Weight .....

1. Have you ever had viral hepatitis? YES / NO WHEN .....

2. Have you had any other infectious diseases? YES / NO WHICH .....

3. Have you had contact with a person suffering from viral hepatitis? YES / NO

4. Have you been vaccinated against hepatitis B type?

- vaccination has been completed YES / NO

- vaccination in progress YES / NO

- I was not vaccinated YES / NO

5. Last hospitalization: WHERE ..... WHEN .....

6. Were surgical procedures performed YES / NO

7. Have you used the services of:

dentistry, ophthalmology, gynecology, urology, ambulance, clinic?

YES / NO WHEN .....

8. Was the continuity of tissues interrupted during the performance of the above-mentioned services? YES / NO

9. Did you have ear(s) pierced? YES / NO

10. Did you have a tattoo or acupuncture performed? YES / NO

11. Have you done the following diagnostic tests:

- blood collection YES / NO

- endoscopy / endoscopy, cystoscopy, bronchoscopy YES / NO

- allergy tests YES / NO

- punctures, biopsies YES / NO

12. Did you have any intravenous, intramuscular, and subcutaneous injections done? YES / NO

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13. Did you take drugs by the parenteral route? YES / NO

14. Have you been treated with antibiotics? YES / NO

15. Have you had a blood transfusion? YES / NO

Signature and stamp of the interviewer physician

Signature of the patient