Regione Autonoma: Friuli Venezia Giulia
Azienda sanitaria universitaria Giuliano Isontina
Unità Operativa di Anestesia e Rianimazione
P.O. Monfalcone
Director Dr. Pier *Eugenio Gobbato*

Preoperative Evaluation Questionnaire
Dear Sir/Madam, This strictly confidential questionnaire is used to provide information on your state of health in order to implement the most suitable treatment for your needs.
You can ask the nurse of the department in which you will be hospitalized to help you fill it out.
Attention: bring all medical documentation for the anesthesiological visit and hospitalization as well as the hospital access sheet that your General Practitioner will issue you.

A - GENERAL DATA
Name and surname: ___________ ___________
Date of birth: __ / __ / ____
weight kg __
height cm __
Address: city _______ (postal code ______) ___________
Profession: ___________
General practitioner: ___________
Reason for visit: ___________

Please tick the answer

B - STATUS OF GENERAL HEALTH		
1) Do you play sports?	YES	NO
2) Do you find it difficult to carry out daily physical activity? If yes, since when?	YES	NO
3) Have you recently suffered from any illness (cough, cold, fever, etc.)?	YES	NO
4) Do you suffer from allergies? If yes, what allergies?	YES	NO
C - MEDICAL HISTORY		
5) Do you smoke? How many cigarettes a day? ………. From how long? ……….	YES	NO
6) Do you drink alcohol? How much? ……….	YES	NO
7) Does anyone in your family (grandparents, parents, uncles) suffer from or died because of:		
- high pressure?	YES	NO
- asthma?	YES	NO
- stroke?	YES	NO
- heart attack?	YES	NO
- suddenly without cause?	YES	NO
8) Do you suffer or have you suffered from heart problems?		
- heart attack?	YES	NO
- angina crisis?	YES	NO
- pulmonary oedema, heart failure?	YES	NO
- arrhythmias (heart beats quickly or irregularly)?	YES	NO
- heart murmur?	YES	NO
- fainting?	YES	NO
	YES	NO

- high pressure? (write your blood pressure ……… mmg) - How many pillows do you use for sleeping?	YES	NO
9) Do you suffer or have you suffered from lung problems?		
- short of breath (after how many steps? ....)	YES	NO
- emphysema?	YES	NO
- asthma?	YES	NO
- how frequent are the crises?	YES	NO
- cough all year round?	YES	NO
10) Have you ever had a haemorrhage for more than 24 hours or have you required transfusions after trauma or tonsil surgery, appendicitis, skin wound sutures?	YES	NO
11) Have you ever experienced a haemorrhage after a tooth extraction that required a new visit for dental or medical treatment?	YES	NO
12) Have you ever seen blood in your urine?	YES	NO
13) Have the previous events (answers 10, 11, 12) occurred in siblings, parents and male maternal relatives?	YES	NO
14) In the last two weeks, have you used medicines containing aspirin or anti-inflammatory painkillers (Metacen. Voltaren, Feldene, Orudis or similar)?	YES	NO
15) Have you ever had a nose bleed that required packing to achieve haemostasis?	YES	NO
16) Do venepuncture sites bleed for more than 15 minutes after applying a cotton swab?	YES	NO
17) Do you suffer from varicose veins?	YES	NO
18) Do you suffer or have you suffered from phlebitis?	YES	NO
19) Do you have diabetes?	YES	NO
20) Are you being treated or have you been treated for diseases of:		
- liver (hepatitis, episode of jaundice)?	YES	NO
- kidney?	YES	NO
- blood?	YES	NO
- thyroid?	YES	NO
- gastrointestinal system?	YES	NO
21) Are you being treated or have you been treated for:		
- headache?	YES	NO
- Seizures?	YES	NO
22) Have you taken or do you take any medications regularly?		
- the contraceptive pill?	YES	NO
- tranquilizers or sleeping pills?	YES	NO
- weight loss medicines?	YES	NO
- laxatives?	YES	NO
- other? (Which? ……….)	YES	NO
23) Are or have you been exposed to the following risk factors?		
- blood transfusions?	YES	NO
- use of drugs?	YES	NO
- casual sex?	YES	NO
- other? ……….	YES	NO
D - ANESTEYESOLOGICAL ANAMNEEYES		
24) Have you ever undergone general anaesthesia?	YES	NO
25) have you ever undergone peripheral anaesthesia? Please specify ……….	YES	NO
26) Have you or has any of your family members had problems related to anaesthesia?		
- nausea?	YES	NO
- vomit?	YES	NO
- headache?	YES	NO
- waking up late?	YES	NO
- prolonged sleepiness?	YES	NO

- high temperature? - other? (please specify)	YES YES	NO NO
27) Do you have removable dentures or contact lenses?	YES	NO

If you have anything else to report, please use the space below:
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………

DATE ………………….

Signature of the patient (or guardian)
……………………………………………………………………………………