|  |  |
| --- | --- |
| Name:……………………………………………………………………… First name:…………………………………………………………………  Date of birth:………………………………………………………………  Body length:…………. cm Weight: …………………kg  Bloodgroup:……………..……….......................................... General practitioner:…………………………………………………… | Planned procedure: □ right □ left  ……………………………………………………………………………………………………………………  Date procedure: ……/……/………  Surgeon: …………………………………………… |

1. **Are you allergic to: if yes , which reaction?**

* Plants, pollen house dust □ yes □ no ……………………………………
* Contrast fluids □ yes □ no ……………………………………
* Latex/rubber □ yes □ no ……………………………………
* Antibiotics Which? □ yes □ no ……………………………………
* Band-Aids Which? □ yes □ no ……………………………………
* Disinfectants Which? □ yes □ no ……………………………………
* Sedatives with the dentist Which? □ yes □ no ……………………………………
* Medication Which? □ yes □ no ………..…………………………
* Other …………………………………………………………

1. **Habits**

* Do you smoke? □ yes □ no ……../day, for………year(s)
* Have you quit smoking? □ yes □ no for……..year(s)
* Do you use alcohol? □ yes □ no ………glasses/day ………glasses per week
* Other stimulants? □ yes □ no Which?...........frequency………………………

**For users of stimulants life-threatening situations are a possibility as a consequence of anesthesia and operation In order to be able to work safely the anesthesiologist has to be notified about what you take**

1. **Are there congenital diseases/deviations present with relatives** □ yes □ no

* Which? ...…...………………………………………………………………………………

1. **Are you in treatment with your general practitioner or with a physician specialist for a specific disease (no operations)** □ yes □ no

* Which? ………………………………………………….……………………………………

1. **Do you suffer from travelling sickness?** □ yes □ no
2. **Do you suffer from diabetes?** □ yes □ no

* Which medication do you take for this?...........................................

…………………………………………………………………………………………………

* Do you use insulin? □ yes □ no
  + Give name/ kind- dosage and timetable:……………………………

………………………………………………………………………………………

1. **Did you already undergo surgery before?** □ yes □ no

* If yes, in what year and for which procedures?
  + In:…………… For:…………………………………………………………………
  + In:…………… For:…………………………………………………………………
  + In:…………… For:…………………………………………………………………

1. **Did you react in an unusual way to sedation?** □ yes □ no

* If yes, Which reaction?.....................................................................

1. **Has any of your relatives had problems during an operation?** □ yes □ no

* If yes, which?..................................................................................

1. **Do you have…?**

* Dentures? □ yes □ no □ upper jaw □ lower jaw □ both
* Artificial teeth? □ yes □ no □ upper jaw □ lower jaw □ both
* Loose teeth? □ yes □ no □ upper jaw □ lower jaw □ both
* Contact lenses? □ yes □ no
* Hearing aid? □ yes □ no

1. **Diseases of lungs and respiratory system.**

* Do you have a wheezing respiration? □ yes □ no
  + If yes, when? ..................................................................
* Do you suffer from asthma? □ yes □ no
* Do you suffer from hay fever □ yes □ no
* Do you suffer from chronic bronchitis? □ yes □ no
* Are you treated for a lung disease □ yes □ no
  + If yes, which?....................................................................
* Have you recently (last month) had a cold? □ yes □ no

1. **Diseases of the eyes.**

* Are you being treated for the moment for an eye disease? □ yes □ no
  + If yes, describe:………………………………………………………………

1. **Heart diseases.**

* Do you suffer from palpitations? □ yes □ no
  + When?................................................................................
* Do you suffer from swollen feet? □ yes □ no
  + When?................................................................................
* Are you treated for a heart disease? □ yes □ no
  + Which?................................................................................
* Can you do light domestic work? □ yes □ no
  + Why not?............................................................................
* Can you go up two floors of flights of stairs without trouble? □ yes □ no
* What trouble do you suffer from?........................................
* Can you perform a serious effort (ex. km of cycling)? □ yes □ no

1. **Diseases of the nervous system.**

* Were/are you (ever) treated for a nervous disease? □ yes □ no
  + Which, describe:………………………………………………………………
* Have you ever lost consciousness? □ yes □ no
* Have you ever had a paralysis? □ yes □ no
* Do you suffer from epilepsy? □ yes □ no
* Do you suffer from tingling in hands and/or feet? □ yes □ no

1. **Back diseases.**

* Do you suffer sometimes of back pain? □ yes □ no
  + Where?..............................................................................
* Does this occur together with pain in the upper or lower legs? □ yes □ no

1. **Diseases of the mouth and neck.**

* Is it possible to move your head in different directions? □ yes □ no
* Can you move the mouth smoothly? □ yes □ no
* Do you feel pain in the neck while moving your head? □ yes □ no
* Does this occur together with pain in the shoulders or the arms? □ yes □ no

1. **Diseases of the live rand the gall bladder.**

* Do or did you suffer from hepatitis? □ yes □ no
* Have you ever experienced problems with the gall bladder? □ yes □ no
* Have you ever experienced problems with your liver? □ yes □ no

1. **Diseases of the kinetic system.**

* Has prosthesis ever been implanted with you? □ yes □ no
* Do you suffer from limitations while executing certain movements

that ARE NOT in connection to the surgery □ yes □ no

* If yes, describe:………………………………………………………..……
* Have you ever been treated for rheumatism? □ yes □ no
* Have you ever been treated for arthritis? □ yes □ no

1. **Diseases of the digestive system.**

* Have you ever had an ulcer? □ yes □ no
* Do you experience problems when swallowing? □ yes □ no
* Are you suffering from nausea or vomiting? □ yes □ no
* Are you suffering from stomach acid? □ yes □ no

1. **Diseases of the blood vessels.**

* Have you ever suffered from varicose veins? □ yes □ no
* Have you ever suffered from phlebitis? □ yes □ no
  + If yes, in what year?..............................................................
* Have you ever undergone treatment for a disease of the blood vessels? □ yes □ no

1. **Problems with blood coagulation**

* Do you take medication to thin out the blood? □ yes □ no
* Do you easily have bruises without a reason? □ yes □ no
* Have you ever needed to contact a physician for a nosebleed? □ yes □ no
* Do you suffer from bleeding gums? □ yes □ no

1. **Diseases of the kidneys and the urinary system.**

* Are you a kidney dialysis patient? □ yes □ no
* Were/are you treated for a kidney disease? □ yes □ no
  + If yes, which?.......................................................................

1. **Have you had recently (last month) influenza?** □ yes □ no
2. **Do you suffer from a contagious disease?** □ yes □ no

* If yes, which?..................................................................................... □ I don’t know

1. **Are you HIV-positive (seropositive)?** □ yes □ no

□ I don’t know

1. **Only for female patients.**

* Could it be you are pregnant? □ yes □ no
* Are you pregnant? □ yes □ no
* Do you regularly have superfluous menstruation? □ yes □ no

1. **Do you take medication? Note clearly which medicine, the dosage in milligram or gram, the number of times a day and the time of intake. Mention here also all painkillers, sleep medication and medication to lose weight.**

**Use the added list for this.**

Document to be filled in by the patient

|  |
| --- |
| Only note here medication you take **daily** or **regularly**  **Personal medication list**  Also note here products you get from the pharmacist or else **without prescription:** painkillers, stomach acid inhibitors, sleeping medicine, vitamins, food supplements, syrups, eye drops… |

|  |
| --- |
| □ I don’t take medication |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| I take **daily**: | | | | | | | |
| FULL name drug + **strength** + shape (tablet, drops, syrup…) | | How much of the drug do you take? + when in the day? | | | | | Remarks:  ex. sober, every 2 days, 1x /week, 1x /month, if necessary, etc |
| Tip: Check the packaging + bring along all packaging to the hospital! | | morning | | noon | evening | before sleeping |
| *Ex. Lasix 40 mg tablet* | | *1 (8u)* | | *0,5 (12u)* |  |  |  |
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| The following medication I **don’t** take daily: | | | | | | | |
| *Ex. Fosamax 70 mg tablet* | *1 (7u)* | |  | |  |  | *Sober 1 x /week* | |
|  |  | |  | |  |  |  | |
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1. **Do you wish to mention something else?** □ yes □ no

………………………………………………………………………………………………………

………………………………………………………………………………………………………

1. **Where can we reach a family member or someone else?**

Cell phone number:……………………………………………………….

Document to be filled in by the patient

**I voluntarily ask to be administered anesthesia and/or perioperative pain policy (analgesia). This is executed and followed up by a recognized anesthesiologist. Perioperative entails the period around the operation.**

CONSENT FORM FOR ANESTHESIA AND PERIOPERATIVE PAIN POLICY

I understand that anesthesia and/or perioperative pain policy pose risks, though I ask anesthesia and/or analgesia as protection and pain reduction during and after the procedure or the investigation. I understand that the type of anesthesia and/or analgesia can be modified without my knowing when this appears necessary.

I understand that rare complications (1/100.000) can occur with every anesthesia and/or analgesia method. Rare complications are: problems with heart and breathing, serious allergic reactions, eye nerve and brain damage and death.

Besides these other complications can occur. These complications are different for the specific type of anesthesia (non-limitative list):

* **General anesthesia**: damage of the vocal chords, teeth, lips, eyes, being awake during the anesthesia; disruptions of memory and confusion; nausea and vomiting; muscle aches; nerve damage; dizziness and turbid vision.
* **Regional anesthesia/ analgesia**: nerve damage, bleeding, infection
* **Spinal/ epidural anesthesia/ analgesia**: nerve damage, bleeding, infection, headache, nausea and vomiting, muscle aches, dizziness and turbid vision.
* **Sedation**: disruptions of memory and confusion;

I understand that the risks of anesthesia and/or analgesia can be greater because of the (medical) condition I’m in.

I understand that the risks of anesthesia and/or analgesia can be greater when I don’t follow guidelines.

I understand that the anesthesiologist can’t guarantee the result of the anesthesia and/or analgesia.

I will be sober before the operation according to the guidelines of the anesthesiologist. I have understood that it is forbidden to eat, to eat candy and to smoke starting 6 hours before the operation. I will take my medication the morning of the operation unless prescribed differently by the treating physician. I know also that I can’t leave the hospital without guidance.

The first 24 hours after the procedure I can’t drive a car, motorcycle or bike and operate machinery. I will not consume alcoholic beverages until 24 hours after the procedure. Someone will be present the first 24 hours after the operation. I will not sign legal documents, and will not take important decisions the first 24 hours after the procedure.

Also I declare to be in agreement with an eventual prolonged stay in the hospital should this appear necessary.

I hereby declare that blood product scan be administered if necessary. (if not in agreement, cross out this sentence and put your signature to the side)

I hereby declare to have read this consent form and if necessary, received clarification of the anesthesiologist.

Made in……………………………………….

Autograph patient or representative Autograph, name and stamp physician