PREOPERATIVE QUESTIONNAIRE AND INFORMATION FOR ADULTS

ANAESTHESIA SECTION
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PREOPERATIVE ANAESTHESIA CONSULTATION T +32 (0)9 332 11 53	ADREMA

Information for Patients

In this document we assess your health condition before the performance of any surgical procedure, test or treatment.
The questionnaire is part of the preoperative examination and is strictly confidential. Either complete the document personally or let a representative do it for you.
By signing this form, you give your consent for anaesthesia. Be sure to read the guidelines for surgery under anaesthetic or sedation.
More information is available on www.uzgent.be/anesthesie.
Here, you can also give the Anaesthesia department your consent to use data from your medical records for scientific research.

Information for Physicians

Which preoperative tests does your patient need? Find out on https://kce.fgov.be (search for 'preoperative tests')..

1 PERSONAL DATA

PATIENT DETAILS

Name: ______________________________

____

Date of birth: ☐☐ - ☐☐ - ☐☐

Telephone no.: ______________________________

CONTACT PERSON/CHAPERON

Contact person's name: ______________________________

____

Contact person's telephone no.: ______________________________

GP: ______________________________

GP's telephone no.: ______________________________

ADDITIONAL PATIENT DETAILS

Age: ______________________________ years

Weight: ______________________________ kg

Height: ______________________________ cm

SURGERY, EXAMINATION OR TREATMENT FOR WHICH YOU ARE BEING ADMITTED

Date: ☐☐ - ☐☐ - ☐☐

Surgery: ______________________________ right – left*

____

____

Name of person accompanying the patient:

____

Telephone number of person accompanying the patient:

____

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*Circle as applicable and give details if possible.

2 PREOPERATIVE QUESTIONNAIRE

ARE YOU ALLERGIC OR HYPERSENSITIVE TO:

Latex	yes – no*	
Plasters	yes – no*	
House dust mites or household dust	yes – no*	
Dental anaesthesia	yes – no*	
Plants, pollen or trees	yes – no*	
Antiseptic agents/iodine	yes – no*	
Medication	yes – no*	which? ______
Food or other?	yes – no*	which? ______

LIFESTYLE

Do you smoke?	yes – no*	How many? ______ /day
		For how long? ______ years
Did you used to smoke?	yes – no*	For how long? ______ years
Do you drink alcohol?	yes – no*	How much? ______ glasses/day/week
Do you regularly take illegal drugs?	yes – no*	Which? ______

DO YOU HAVE ...

Dentures?	yes – no*	
False teeth?	yes – no*	
Any loose teeth?	yes – no*	Which? ______
Contact lenses?	yes – no*	
A hearing aid?	yes – no*	
Piercings?	yes – no*	If so, please remove these at home
False nails?	yes – no*	If so, please remove these at home
A pacemaker or stimulator?	yes – no*	
An implanted pump (for pain management or other medical reasons)?	yes – no*	

HAVE YOU PREVIOUSLY UNDERGONE SURGERY? yes – no*

If yes:

Which procedure(s)?	When?	Which hospital?

WERE THERE ANY PROBLEMS DURING PREVIOUS PROCEDURES? yes – no*

If yes: Which?	When?	Which type of anaesthetic did you receive?
		General / partial / local*
		General / partial / local*
		General / partial / local*

*Circle as applicable and give details if possible.

FAMILY HISTORY

Has anyone in your family ever responded badly to anaesthesia?	yes – no*
Do you have a family history of congenital defects?	yes – no*

DISORDERS OF THE THROAT AND MOUTH

Do you have problems with opening your mouth?	yes – no*	To check, insert 2 fingers on top of one another into your mouth
Do you have problems with moving your head?	yes – no*	
Do you have pain in your neck, shoulders or arms when you move your head?	yes – no*	

ONLY FOR FEMALE PATIENTS

Are you, or could you be, pregnant?	yes – no*
Do you have very heavy periods?	yes – no*

INFECTIOUS DISEASES

Do you have an infectious disease?	yes – no*

Which? ______________________________

DIABETES

Are you diabetic?	yes – no*

DISORDERS OF THE LUNGS AND RESPIRATORY SYSTEM

Do you suffer from wheezing?	yes – no*
Do you have asthma or hay fever?	yes – no*
Have you ever been treated for a lung disorder?	yes – no*

DISORDERS OF THE HEART AND ARTERIES

Do you sometimes experience pain or tightness in your arm or chest on exertion?	yes – no*
Do you suffer from heart palpitations?	yes – no*
Do you occasionally have swollen feet?	yes – no*
Do you sleep half sitting up?	yes – no*
Do you have problems when performing domestic chores?	yes – no*
Are you short of breath after climbing 2 flights of stairs?	yes – no*
Are you being treated for a heart disorder?	yes – no*
Have you ever had phlebitis?	yes – no*
Have you ever had a vascular disorder?	yes – no*
What is your normal blood pressure?	_____ / _____

DISORDERS OF THE KIDNEYS AND URINARY SYSTEM

Are you a kidney dialysis patient?	yes – no*
Have you ever been treated for a kidney disorder?	yes – no*

Which? ______________________________

*Circle as applicable and give details if possible.

PROBLEMS WITH COAGULATION OF THE BLOOD

Do you bruise easily? yes – no*

Have you ever suffered from nosebleeds? yes – no*

Do you suffer from bleeding gums? yes – no*

DISORDERS OF THE DIGESTIVE SYSTEM AND LIVER

Do you suffer from heartburn? yes – no*

Do you suffer from nausea or vomiting? yes – no*

Do you suffer from travel sickness? yes – no*

When? ____________________

Have you ever had jaundice? yes – no*

What type? ____________________

DISORDERS OF THE NERVOUS SYSTEM

Do you suffer from epilepsy or falling sickness? yes – no*

Have you ever been treated by a neurologist or psychiatrist? yes – no*

Do you suffer from tingling, spasms or numbness in your limbs? yes – no*

Where? ____________________

DISORDERS OF THE LOCOMOTOR SYSTEM

Do you occasionally have back pain? yes – no*

Do you have rheumatism or arthritis? yes – no*

Do you have a prosthetic shoulder, knee or hip? yes – no*

MEDICATION

Are you taking any medication? yes – no*

If yes, please read the information on home medication and bring the completed medication schedule with you.
You can find these documents in the admissions folder or on www.uzgent.be/opnamedocumenten.

*Circle as applicable
and give details if possible.

3 INFORMATION STATEMENT ON SCIENTIFIC RESEARCH

☐ I give permission to the Anaesthesia department to use data from my medical records for scientific research.

You will undergo an operation, treatment or test under local or general anaesthesia in the near future. For this to be done safely, the anaesthetist will need **data from your medical record**: your medical history and parameters (such as your blood pressure, heart rate and oxygen saturation) that are automatically recorded during the procedure.

USE OF DATA FOR SCIENTIFIC RESEARCH

These data are also very useful for the scientific research conducted by the Anaesthesia department. With this research, we want to further expand our knowledge of anaesthesia in various conditions for the benefit of future patients.

We therefore ask **your permission to use the data from your medical file for our scientific research afterwards**. We use the data only for observational scientific research in perioperative medicine and for internal quality controls at the Anaesthesia department.

WHO CAN ACCESS YOUR DATA?

If you give your consent, doctors, junior doctors and/or medical students can access your data. However, your personal and clinical data will be pseudonymised. That means that **no link with your personal medical file will be possible**.

The research will always be supervised and directed by staff of the Anaesthesia department. All employees are bound by medical confidentiality or sign a confidentiality form as a guarantee.

VOLUNTARY COOPERATION

You can **voluntarily** decide whether or not to participate in our scientific research. You do not have to give a reason if you prefer not to. A refusal does not affect your further treatment or the relationship with your treating physician.

You may withdraw your consent at any time by informing your anaesthetist. Please note that we cannot delete data that has already been processed.

PROTECTION OF YOUR PERSONAL DATA

UZ Gent carefully watches over the protection of your personal data. We only carry out scientific studies that have been **approved by the Ethics Committee** of UZ Gent. The Ethics Committee safeguards the rights of patients.

For more information on the protection of your personal data, please contact the **Data Protection Officer** at UZ Gent, Katya Van Driessche, dpo@uzgent.be.

YOUR CONSENT

If you agree, please tick the box above.
If you do not wish to participate, please leave the box blank.

MORE INFORMATION

If you have any further questions, please speak to your anaesthetist. Or call the Anaesthesia department on 09 332 32 81.

*Circle as applicable
and give details if possible.

4 GUIDELINES FOR AN OPERATION UNDER ANAESTHESIA OR SEDATION

- I will comply with the **agreements concerning fasting**.
  Inhaling stomach contents while under anaesthesia or sedation can be dangerous.

- I will only take the **medicines** prescribed by my doctor.
  Some medicines have more severe side effects during anaesthesia or sedation.

- I will remove all **jewellery and piercings** (including those in less visible places) or will have these removed beforehand.
  Jewellery and piercings can cause severe injuries (tearings, burns) during a procedure.

- I will **not drink alcohol** in the 24-hour period before the procedure. Alcohol can have severe side effects after anaesthesia or surgery.

- I will refrain from taking **any important decisions** right after the operation and take into consideration that I may not be able to work the following day. An operation or anaesthesia can have a lasting effect even the next day.

- I give my permission for **my data** to be processed anonymously (telephone/digital follow-up and survey).
  This data can be used in the context of internal quality controls.

Only for one day admission

- I will **not drive myself** on the day of the procedure and will be accompanied by ______________________________ (name).
  The ability to safely use the roads (car, bicycle, motorbike, public transport etc.) is reduced by anesthesia or a surgical procedure (e.g. eye surgery).

- If there are any problems during the first night after the treatment, I can contact ______________________________
  (name of partner, family member, friend, person accompanying the patient or other).

- I will stay in the hospital overnight if the surgeon and/or anaesthesiologist consider this is necessary.

5 CONSENT FOR ANAESTHESIA

I received sufficient information about the procedure, the exam, the anaesthesia, and the postoperative care.
I have read the information on anaesthesia available on www.uzgent.be/anesthesie or in the brochure of the Day Surgery Clinic.
I undertake to follow all recommendations strictly.

I agree to undergo a surgical procedure or examination under anaesthesia.

Read and approved

Date: ______ / ______ / ______

Signature: ______________________________

*Circle as applicable
and give details if possible.