Clinique Hartmann
26 Bd Victor Hugo
92200 Neuilly Sur Seine

Preanesthetic Questionnaire

Professeur Philippe MASSIN

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This questionnaire is intended to inform the anaesthesiologist who will take care of you during your anaesthesia. He will inform him about your state of health and guide the pre-anaesthetic examination.

Name, first name: **……..**
Age: ……. Sex: …… Height: …… Weight: ……. Profession: ……
Home address:
……
…….. ☎ : ……..

Surgeon's name: **Pr Philippe MASSIN**
Type of operation: ……
……
Date of operation: ……
What type of physical exercise do you do regularly (walking, running, cycling..., or nothing)? ……..
……

Previous Surgical Procedures:
……....
……....

Date, place, type of operation and anaesthesia, complications:
1- ……
2- ……
3- ……

Have you ever been hospitalized for a non-surgical illness?
1. ……
2. ……
3. ……

Have you had or still have any of these conditions? (tick the appropriate box).

- ☐ cardiovascular disease
- ☐ High blood pressure
- ☐ Brain condition
- ☐ Kidney disease
- ☐ Hepatic disease
- ☐ Diabetes
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Convulsions, epilepsy
- ☐ Rheumatism
- ☐ Polyarthritis
- ☐ Bronchopulmonary diseases (asthma, chronic bronchitis, etc.)
- ☐ Tuberculosis

Are you allergic, or do you have any abnormal reactions after taking certain medications (i.e.: Penicillin…)
Indicate the products involved and the type of reaction: ……

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Have you ever received blood transfusions?
☐ Yes ☐ No
If yes, when? ……..

Did you receive growth hormone before 1984?
☐ Yes ☐ No

Has any member of your family died of Creutzfeldt-Jacob disease?
☐ Yes ☐ No
If Yes, when and who? ……..

Indicate the medications you are currently taking, prescribed by your doctor as well as those you are taking without a prescription (e.g. aspirin, sleeping pills, laxatives, diuretics).
Name of drug and doses:
1. ……
2. ……
3. ……

Do you have any dental problems? (tick the appropriate box)
☐ False tooth(s) ☐ Crown (s)
☐ Wobbly tooth(s) ☐ Tooth(s) requiring care
☐ Loose dental device

Are you aware of any complications related to anesthesia in your immediate family?
☐ Yes ☐ No
If yes, which one? ……..……..

At the moment, have you (tick the corresponding box)
☐ Chest pain ☐ Loss of consciousness, syncope
☐ Palpitations ☐ Breathing difficulties at night
☐ Ankle swelling ☐ Rapid shortness of breath during exercise (walking, climbing stairs)
☐ Frequent cough ☐ Recent weight loss
☐ Muscle cramps ☐ Walking difficulties
☐ Urinary burns ☐ back pain
☐ Pregnancy

Do you smoke?
☐ Yes ☐ No
Number of cigarettes/days: ……
Do you drink alcoholic beverages?
Every day: ☐ Yes ☐ No, How much? ……

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Questions for the anaesthesiologist

1. ……
2. ……