Anesthesia Service Casa di Cura "S. Camillo"
Supervisor Dr. R. Marchesi

PREOPERATIVE SELF-ASSESSMENT QUESTIONNAIRE

Dear Madam, Dear Sir,
kindly fill the questionnaire; your answers will allow the Anesthesiologist to take the anesthetic measures most appropriate to you.

Surname ..... Name .....

Date of birth ..... Age..... Weight ..... Height cm .....

Are you allergic to : pollen, substances, fruits, other foods ? NO YES If so, which ones ?.....
.....

Are you allergic to medicines ? NO YES If so, which ones?.....
.....

Are you allergic to rubber ? NO YES

Are you a smoker ? NO YES If so, since when ?.....

Did you quit smoking ? YES Since when ?.....

Do you regularly drink wine or other alcoholic beverage NO YES If so, how much ?.....

Do you use or have you made use of drugs ? NO YES If so, which ones ?.....
.....

Have you undergone blood transfusions ? NO YES .....

Do you have dentures or unstable teeth ? NO YES .....

Do you have hearing aids or contact lenses ? NO YES .....

Do you easily have bruises and hematomas ? NO YES .....

Do you bleed for a long time after an injury ? NO YES .....

Are you breathless after a flight of stairs ? NO YES .....

Are there hereditary diseases in your family ? NO YES .....

Do you suffer or have suffered from any of the following diseases ?

Bronchial asthma NO YES .....

Chronic bronchitis NO YES .....

Tuberculosis NO YES.....

Pulmonary emphysema NO YES.....

Pulmonary embolism NO YES .....

Myocardial infarction or angina NO YES.....

Cardiac arrhythmias NO YES.....