

INFORMATION REGARDING THE PATIENT'S HEALTH CONDITION

All information provided is covered by medical confidentiality and is intended to ensure your safety.

Please answer the following questions carefully. If you have difficulty answering any question, please leave it unanswered and discuss any concerns with your attending physician.

The questions below are intended to collect the information necessary to select the appropriate treatment and type of anesthesia before the procedure.

Patient's surname, first name: PESEL

--	--	--	--	--	--	--	--	--	--

Telephone: Address:

Sex: Female ☐ Male ☐

Do you generally consider yourself healthy? YES ☐ NO ☐

Have you been treated in hospital during the last 2 years? YES ☐ NO ☐

If yes, for what reason?

Are you currently receiving treatment for any condition? YES ☐ NO ☐

If yes, for what condition?

Do you take any medications? (especially aspirin or anticoagulants) YES ☐ NO ☐

If yes, which ones?

Are you allergic to anything? YES ☐ NO ☐

If yes, what?

Do you experience any of the following?

Shortness of breath: YES ☐ NO ☐

Hives: YES ☐ NO ☐

Swelling: YES ☐ NO ☐

Itching: YES ☐ NO ☐

Do you have a tendency to bleed? YES ☐ NO ☐

Have you ever experienced fainting or loss of consciousness? YES ☐ NO ☐

Do you have a pacemaker? YES ☐ NO ☐

Have you ever suffered from, or do you currently suffer from, any of the following conditions?

Heart diseases (myocardial infarction, coronary artery disease, heart defect, cardiac arrhythmias, myocarditis) YES ☐ NO ☐

Other cardiovascular diseases (high blood pressure, low blood pressure, fainting, shortness of breath) YES ☐ NO ☐

Blood vessel diseases (varicose veins, phlebitis, poor circulation in the limbs, lower-leg pain when walking) YES ☐ NO ☐

Lung diseases (emphysema, pneumonia, tuberculosis, asthma, chronic bronchitis) YES ☐ NO ☐

Digestive system diseases (gastric or duodenal ulcer disease, intestinal diseases) YES ☐ NO ☐

Liver diseases (gallstones, jaundice, liver cirrhosis) YES ☐ NO ☐

Urinary system diseases (kidney inflammation, kidney stones, difficulty urinating) YES ☐ NO ☐

Metabolic disorders (diabetes, gout) YES ☐ NO ☐

Thyroid diseases (hyperthyroidism, hypothyroidism, goiter) YES ☐ NO ☐

Neurological diseases (epilepsy, paresis, loss of consciousness, paralysis, sensory disturbances) YES ☐ NO ☐

Musculoskeletal diseases (radicular pain, degenerative changes of the spine or joints, conditions following fractures)

YES ☐ NO ☐

Blood and clotting disorders (hemophilia, anemia, tendency to bruising/bleeding, nosebleeds, prolonged bleeding after tooth extraction)

YES ☐ NO ☐

Eye diseases (glaucoma)

YES ☐ NO ☐

Mood disorders (depression, neurosis/anxiety disorder)

YES ☐ NO ☐

Infectious diseases

YES ☐ NO ☐

Rheumatic disease

YES ☐ NO ☐

Osteoporosis

YES ☐ NO ☐

Other medical conditions:

What was your most recent blood pressure measurement?.....

Have you ever undergone surgery? YES ☐ NO ☐

If yes, when and for what reason?

Did you tolerate the anesthesia well? YES ☐ NO ☐

Have you ever received a blood transfusion? YES ☐ NO ☐

If yes, when and for what reason?

Do you smoke tobacco? YES ☐ NO ☐

Do you drink alcohol? YES ☐ NO ☐

Do you take sedatives, sleeping pills, or recreational drugs? YES ☐ NO ☐

If yes, which ones?

Do you have dentures or loose teeth? YES ☐ NO ☐

Have you been vaccinated against viral hepatitis? YES ☐ NO ☐

Questions for women:

Are you pregnant? YES ☐ NO ☐

Are you breastfeeding? YES ☐ NO ☐

FOR 12 HOURS AFTER GENERAL ANESTHESIA, THE FOLLOWING ARE PROHIBITED:

- driving a car or other vehicles, and operating complex equipment and machinery;
- drinking alcohol;
- performing any other activities requiring full psychophysical fitness.

PATIENT'S DECLARATION

- I hereby declare that the information provided above is true and accurate. I undertake to report any changes in my health condition at my next visit after such changes occur.
- I hereby declare that I have been informed of the obligation to return home accompanied by another person if the examination is performed under general anesthesia.
- I hereby declare that I have been informed of my right to access and correct my personal data.

Date:

Patient's signature:

I consent to the performance of examinations and other healthcare services at Bodyclinic Multispecialist Medical Clinic, located at 4 Sierakowskiego Street, Unit U3, Warsaw.

Date:

Patient's signature: