BASIC MEDICAL QUESTIONNAIRE

Please read carefully and answer most accurate

PATIENT PERSONAL DATA		
First and last name:		
Date of birth:		
Address:		
City, country:		
Phone:		
Profession:		
Passport or ID number:		
BASIC MEDICAL INFORMATION		
BODY WEIGHT (kg):		
HEIGHT (cm):		
Are you taking any medications on regular or occasional basis?	YES	NO
If your answer is YES; please write all medications you take regularly:		
Medication name:	Dosage	How often on daily basis
Are you allergic on any medications?	YES	NO
If your answer is YES, please write medications you are allergic to:		
Medication name:		

Are you allergic on any food or anything else? (on latex, iodine, contrasts and other)	YES	NO
If your answer is YES, please write on what are you allergic and what kind of reaction you had (rash, itching, strangling, heart failure, shock and similar):		
Are you pregnant?	YES	NO
Have you ever been treated for overmuch bleeding?	YES	NO
Did any of your family and relatives had any **complications during anesthesia?**	YES	NO
If your answer is YES, please write about it:		
Are you a smoker?	YES	NO
If your answer is YES, how much are you smoking on daily basis?		
Are you drinking alcohol? OFTEN	OCCASIONALLY	NO
Are you taking any herbal and natural medications? (Ginseng, garlic and similar)	YES	NO
If your answer is YES, please write what medications?		
Have you had raised body temperature, cold or flue in last month?	YES	NO
Have you been severely diseased in last 2 years?	YES	NO
If your answer is YES, please write about it:		
Please write about your **previous surgeries** (if you had them), and when were you operated:		
Did anesthesia went fine?	YES	NO

Are you suffering from any of listed diseases?

Raised blood pressure?	YES	NO

Hear disease?	YES	NO
If your answer is YES, please write what exactly:		
Bloodstream or blood vessel diseases?	YES	NO
If your answer is YES, please write what exactly:		
Lungs and respiratory system diseases?	YES	NO
If your answer is YES, please write what exactly:		
asthma?	YES	NO
Are you using a pump (e.g. Ventolin, Serevent)?	YES	NO
Pump's name:		
Liver diseases?	YES	NO
If your answer is YES, please write what exactly:		
Diabetes?	YES	NO
Are you taking insulin?	YES	NO
Insulin name:		
Are you taking any other medications for diabetes?	YES	NO
Thyroid disease?	YES	NO
If your answer is YES, please write what exactly:		
Kidney or urinary pathways diseases?	YES	NO
If your answer is YES, please write what exactly:		
Nervous system disease?	YES	NO
If your answer is YES, please write what exactly:		
Epilepsy	YES	NO
Last attack was on:		
Stroke?	YES	NO
When?		
Giddiness?	YES	NO
Digestive tract diseases?	YES	NO

If your answer is YES, please write what exactly:		
Blood disease or coagulation disorder?	YES	NO
If your answer is YES, please write what exactly:		
Trombosis or emobly or embolism?	YES	NO
If your answer is YES, please write what exactly:		
Uare you taking any medications against blood coagulation krvi?	YES	NO
If your answer is YES, please write what exactly:		
Hepatitis or liver diseases?	YES	NO
If your answer is YES, please write what exactly:		
Kidney diseases?	YES	NO
If your answer is YES, please write what exactly:		
Thyroid diseases?	YES	NO
If your answer is YES, please write what exactly:		
Depression or any other psychiatric problems?	YES	NO
If your answer is YES, please write what exactly:		
Bones, joints or muscle diseases?	YES	NO
If your answer is YES, please write what exactly:		
Do you have problems with breathing through the nose?	YES	NO
Do you have any other medical problem that was not mentioned earlier in this questionnaire?	YES	NO
If your answer is YES, please write what exactly:		

I, signed bellow, state that I fully understood all the questions, received needed explanations and that data in this questionnaire is authentic.

Date: Signature: