LANDSPÍTALI háskólasjúkrahús

Pre- Anesthesia Form

Date. (dd/mm/yyyy)								
		T						
Age Weig	tht (kg)	Heig	ht (cm)					
a. Have you had a general an b. Have you had a spinal or a		Yes	No 🗆	7 a. Do you sr b. Do you h	moke? ave alcohol addiction?		Yes	No _
a. Any nausea/vomit after sur b. Adverse reagtion to anesth c. Do any close relatives have to anesthesia?	esia?	Yes	No	a. Are you a Specify?	ave drug addiction? llergic to any medication ave any other allergies?		Yes	No
a. Do you have asthma, chronor emphysema?b. Do you suffer from sleep at c. Have you had frequent pnellung infections?d. Have you got a chronic couper sputum production?	pnea? eumonias, or other	Yes	No		own all current medica			
a. Do you suffer from high bl b. Do you have irregular hear c. Do you have chest pain due d. Have you had a heart attact e. Do you have a heart valves f. Do you have a pacemaker?	t beat? e to heart disease? k?	Yes	No					
a. Have you had a stroke or n b. Do you have epilepsy or se c. Do you have any physical re	eizure disorder?	Yes	No 🗆					
Do you have or have yo any of these following d a. Clotting disorde or other bb. Kidney disease?	iseases: lood disease?	Yes		ŕ	nen: ou be pregnant? anything you would li	ike to mention?	Yes	No
c. Yellow jaundice or liver disc d. Regurgitation? e. Diabetes? f. Thyroid problem? g. Malignant disease? h. Rheumatism or arthritis? i. Severe weight problems (ob. g. Treatment for Psychiatric D	pesity)?			- Is dicite	angama you would ii	to menuon:		
Physician only					ASA	A 1 2 3	4 5 6	6
Úrvinnsla								

Undirskrift