Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next of kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social securitynumber (11 digits): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Have you had Covid? Yes □ No □

Out of isolation (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_ Weight: \_\_\_\_NB! Important for anaesthesia!

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | No | Yes |  | No | Yes |
| Do you have any allergies? (Circle relevant)  Pharmaceuticals Latex Other  If **Yes**, please provide further details under other/additional information. |  |  | Have you ever had issues or problems with anaesthesia or anaesthesia given in the back (spinal, epidural)? If **Yes**, please state where and when this occured. Describe the event under other/additional information. |  |  |
| Do you have high blood pressure or are you under treatment for high blood pressure? |  |  | Do you smoke/use snuff, chewing tobacco? How much? If you used to, when did you quit? |  |  |
| Have you had cardiac arrest/heart attack? Do you have a cardiovascular disease, e.g. angina, chest pain, heart failure, myocardial infarction, arrhytmia, pacemaker or claudication/poor circulation in your legs? |  |  | Do you have any other disease, issues or problems that needs consideration or that require medicamental treatment? If **Yes**, state what: |  |  |
| Does anyone in your family have a heart condition? If so, what kind? |  |  | What is your native language?  Could you benefit from using an interpreter? |  |  |
| Do you suffer from lung disease, COPD or sleep apnea? |  |  | Have you had surgery in Normay or abroad previously?  Cause? Where? When? | | |
| Do you suffer from kidney disease or do you have problem with your urinary tract? |  |  |
| Do you suffer from liver, bilary/gallbladder or bowel disease? |  |  |
| Do you have a neurological illness? Have you had a stroke, TIA, cerebral haemorrhage/bleed, seizures or epilepsy? |  |  | Have you had dental treatment, surgery or had a stay at an istitution abroad for the last 12 months? |  |  |
| Do you suffer from rheumatic illness, gout or musculoskelatal illness? |  |  | Do you live with someone who has been diagnosed with MRSA, VRE or ESBL? |  |  |
| Do you have problems with neck or issues with opening your mouth wide? |  |  | Other/additional information: | | |
| Do you suffer from acid reflux, reflux illness, GERD/GORD or heartburn? |  |  |
| Do you have Diabetes/high blood sugar? If **Yes**, are you treated with (circle relevant):  Insulin Tablets Diet-alone |  |  |
| Do you or have you had psychological illness, anxiety/panic-attacks, depression or phobias? |  |  |
| Do you illicit drugs? If so, what kind? |  |  |
| Do you hav a blood-born illness or infection disease? Tuberculosis, HIV, Hepatitis or other? |  |  |
| Do you bleed easily or unusually long from small wounds or dental treatment? |  |  | If you use medicines, what type and what dosage?  Date: Sign.: | | |
| Do you get easily nauseated or suffer from travel sickness? |  |  |
| Do you breastfeed or are you pregnant? |  |  |
| Do you suffer from gum disease or have loos/injured teeth? Dental prosthesis? |  |  |
| Do you have braces, false-teeth/dentures, dental jewellery or piercing in your mouth? Hearing aid? |  |  |