

Patienten-Etikette

**ANAESTHESIOLOGY AND
INTENSIVE CARE DEPARTMENT**
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ANAESTHESIA QUESTIONNAIRE

Please complete front and back, marking with an «X» as appropriate and underlining or indicating as applicable.

Last name _____
First name _____
Date of birth _____
Height _____ Weight _____

PLANNED OPERATION

Which operation? _____
Who is the surgeon? _____
Date of the planned operation? _____
Have you had a check-up within the last 12 months? _____ yes no
If yes, who was the doctor? _____

PREVIOUS OPERATIONS

TYPE OF ANAESTHESIA:

When? _____	<input type="checkbox"/> general
Which? _____	<input type="checkbox"/> regional
When? _____	<input type="checkbox"/> general
Which? _____	<input type="checkbox"/> regional
When? _____	<input type="checkbox"/> general
Which? _____	<input type="checkbox"/> regional
When? _____	<input type="checkbox"/> general
Which? _____	<input type="checkbox"/> regional

Did you suffer from complications from the anaesthesia? yes no

If yes, which? _____

Did complaints occur after the anaesthesia? yes no

Nausea/vomiting, dizziness, shivering, breathing difficulties, sore throat, swallowing difficulties, headache, hearing problems, sensory disturbances, bleeding
Other? _____

Have any blood relatives had complications related to an anaesthesia? yes no

If yes, which? _____

GENERAL QUESTIONS

Have you been in a doctor's care recently? yes no

If yes, why? _____

Do you smoke regularly? yes no

If yes, how many cigarettes? _____

Do you drink alcohol on a regular basis? yes no

If yes, how much? _____

Did or do you take drugs? yes no

If yes, which? _____

Could you be pregnant? yes no

Have you ever had a blood transfusion? yes no

In the last 3 months
Did you tolerate the transfusion well? yes no

Do you wear dentures? yes no

Removable dentures, pin tooth, implants, jacket crowns

Do you have loose teeth? yes no

Do you wear a hearing aid? yes no

Do you have a cardiac pacemaker or a defibrillator? yes no

HAVE YOU SUFFERED OR DO YOU SUFFER FROM DISORDERS OF THE FOLLOWING ORGAN SYSTEMS?

Please complete, marking with an «X» as appropriate and underlining as applicable.

Heart yes no

Heart attack, angina pectoris, heart defect, arrhythmia, heart muscle inflammation, shortness of breath during exertion or while lying down

or _____

Circulation yes no

High blood pressure, low blood pressure

or _____

Vessels yes no

Circulatory disorders, varicose veins, thrombosis

or _____

Lungs and airways yes no

Pneumonia, tuberculosis, pneumoconiosis, pulmonary emphysema, asthma, chronic bronchitis, pulmonary embolism, cough/expectoration

or _____

Oesophagus, stomach, bowels, liver, gall bladder yes no

Heartburn, frequent vomiting, ulcer, digestive problems, gallstones, hepatitis

or _____

Metabolism yes no

Diabetes, thyroid, gout, high blood lipids

or _____

Infectious diseases yes no

Hepatitis, HIV

or _____

Kidneys and urinary tract yes no

Kidney stones, inflammations, high kidney readings, dialysis, cystitis

or _____

Eyes yes no

Cataract, glaucoma, pupil difference, sight defects, poor eyesight

or _____

Musculoskeletal system yes no

Joint disorders, back complaints, postural deformity, shoulder or arm pain

Have you or any blood relatives suffered from muscle disorders? yes no

Blood yes no

Coagulation disorders (frequent nosebleeds and bleeding gums, bruising), anaemia, very heavy periods, other heavy bleeding

or _____

Nerves yes no

Stroke or TIA, seizures (epilepsy), paralysis, sensory disturbances, forgetfulness, lack of concentration, headache, migraine

or _____

Mind: depression yes no

or _____

Allergies yes no

Hay fever, asthma, hypersensitivity to medicines, latex, foods, iodine, adhesive plaster, contrast agents, cosmetics, metals

or _____

Are you taking medicine(s)?

(Please bring all medicines with you to the hospital)

Which? _____

Any other conditions or specifics not listed?

I hereby confirm that I have answered all the questions truthfully. I have read the anaesthesia brochure and information sheet. Swiss law stipulates that patients must be informed about the procedure ahead of time, at least 1-3 days before the operation. We therefore invite you to attend an anaesthesia consultation at your next convenience.

Place _____

Date _____

Patient's signature _____

Please fill out the questionnaire and send it back to the hospital together with the other documents. If the operation has been scheduled at short notice, bring the questionnaire (or a copy) with you to the anaesthesia consultation at the hospital.