ZUGER Kantonsspital

Anaesthesia questionnaire

→ **Institut für Anästhesie und Intensivmedizin**

Zuger Kantonsspital
Institut für Anästhesie und Intensivmedizin
Präoperative Sprechstunde
Landhausstrasse 11
CH-6340 Baar
T 041 399 33 15, praeoperative.sprechstunde@zgks.ch

Patient label

Please complete and sign this questionnaire, and then return it promptly to the address above. Please contact us or your general practitioner if you have any questions.

PERSONAL INFORMATION

Surname _____ First name _____

Date of birth _____ E-mail _____

Private telephone number _____ Mobile telephone _____

Street, house no. _____ Postcode, town/city _____

Height _____ cm Weight _____ kg

Who is your general practitioner (name, address, telephone, e-mail)?

_____

Last check-up by the cardiologist (heart specialist)

Where (Practice) _____ When _____

STATE OF HEALTH

Can you climb two flights of stairs without becoming short of breath?	☐ Yes	☐ No
Do you experience shortness of breath in everyday life?	☐ Yes	☐ No
Do you sometimes feel pain, pressure or tightness in your chest?	☐ Yes	☐ No

Have you ever had or do you currently have one or more of the following problems?

Coronary artery disease (e.g. angina pectoris, heart attack, stents)		☐ Yes	☐ No
Cardiac arrhythmia		☐ Yes	☐ No
Heart valve disease		☐ Yes	☐ No
Do you wear a pacemaker or carry a defibrillator? If so, please bring your identification card with you.		☐ Yes	☐ No
Lung disease (e.g. asthma, chronic bronchitis, home oxygen therapy)		☐ Yes	☐ No
Pulmonary embolism and/or thrombosis		☐ Yes	☐ No
Blood clotting disorder (e.g. frequent nosebleeds or bleeding from the gums)		☐ Yes	☐ No
Stroke (brain haemorrhage or cerebral infarction)		☐ Yes	☐ No
Muscular diseases (e.g. malignant hyperthermia, myopathy, muscular dystrophy)		☐ Yes	☐ No
Kidney disease		☐ Yes	☐ No
Anaemia		☐ Yes	☐ No
Diabetes without insulin treatment / with insulin treatment	☐ Without	☐ With	☐ No

ZUGER Kantonsspital

Anaesthesia questionnaire

Have you ever had or do you currently have one or more of the following problems?		
High blood pressure	☐ Yes	☐ No
Liver disease (e.g. jaundice, hepatitis)	☐ Yes	☐ No
Over-active or under-active thyroid or other metabolic disorders	☐ Yes	☐ No
Neurological disease (e.g. epilepsy, Parkinson's disease, paralysis, chronic pain)	☐ Yes	☐ No
Mental illness (e.g. claustrophobia, panic attacks, depression)	☐ Yes	☐ No
Sleep apnoea (If you have a therapy device, please bring it with you on the day of the operation)	☐ Yes	☐ No
Stomach problems (e.g. acid reflux, heartburn, gastric bypass, gastric band)	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Spinal problems (e.g. slipped disc)	☐ Yes	☐ No
HIV, tuberculosis	☐ Yes	☐ No

GENERAL QUESTIONS

Do you have any allergies (e.g. to medication, latex, iodine, disinfectants or food items)? If so, which?	☐ Yes	☐ No
Could you be pregnant or are you breastfeeding?	☐ Yes	☐ No
Do you take blood-thinning medication?	☐ Yes	☐ No
Do you have removable dentures or loose teeth?	☐ Yes	☐ No
Do you drink alcohol several times per week? If so, how much?	☐ Yes	☐ No
Do you smoke? If so, how much?	☐ Yes	☐ No
Do you take drugs? If so, which?	☐ Yes	☐ No
Have you or any blood relative ever had problems with anaesthesia? If so, what?	☐ Yes	☐ No
Do you accept blood products in the event of life-threatening bleeding during surgery?	☐ Yes	☐ No
Do you have a living will? If so, please bring a copy with you.	☐ Yes	☐ No

PREVIOUS OPERATIONS

When? Which? _____

MEDICATION

What medication are you taking? If you have a medication plan, please bring it with you.

Name:	Dose:
Name:	Dose:
Name:	Dose:
Name:	Dose:
Name:	Dose:
Name:	Dose:
Name:	Dose:

REMARKS/QUESTIONS

_____

_____

Place, date _____ Patient's or legal representative's signature _____

38240 . 2/2024