Anaesthesia Health Questionnaire

Family name: **First name:**

Date of birth:

Dear Patient

It is important for us to ensure your anaesthesia is carried out as carefully and as safely as possible. To do this, we need information about your state of health. Please complete the following questionnaire truthfully and as completely as possible and bring it along to the pre-anaesthesia consultation fully completed.
If you are unclear about any issues, you can clear these up with the anaesthetist directly.
It is essential you arrange an appointment with your GP (ideally at least one week before your pre-anaesthesia consultation) if:

- ✓ you are aged over 65
- ✓ you have checked at least one red (grey) box
- ✓ you are scheduled to have any of the following operations: total prostate removal, hip replacement, shoulder replacement, knee replacement, revision of a hip or knee replacement

Height: **Weight:**

Planned surgery:

Previous operations and anaesthesia?
Which? When?

Have you or any of your blood relatives ever had problems with anaesthesia? If so, what problems?

State of health and exercise tolerance:
Please answer the following questions and state whether you are receiving or have received medical treatment for one or more of the following conditions.

Brain / Nerves / Mental health:		
Neurological disease (e.g. epilepsy, Parkinson's disease, multiple sclerosis, paralysis)	☐ yes	☐ no
Mental illnesses (e.g. depression, anxiety, schizophrenia)	☐ yes	☐ no
Memory disorders (e.g. dementia)	☐ yes	☐ no
Have you had a stroke?	☐ yes	☐ no
Lungs / Airways:		
Asthma	☐ yes	☐ no
Lung disease (e.g. COPD, pulmonary fibrosis, home oxygen therapy)	☐ yes	☐ no
Sleep apnoea	☐ yes	☐ no
Do you wear a CPAP mask at night?	☐ yes	☐ no
Cardiovascular system:		
Diseases of the coronary arteries (e.g. angina pectoris, stents, myocardial infarction)	☐ yes	☐ no
Diseases of the heart valves	☐ yes	☐ no
Heart rhythm disturbances	☐ yes	☐ no
Do you have a pacemaker or an internal defibrillator?	☐ yes	☐ no
High blood pressure	☐ yes	☐ no
Thrombosis and/or embolism	☐ yes	☐ no
Circulatory disorders or aneurysms	☐ yes	☐ no
Exercise tolerance:		
Are you able to climb 2 flights of stairs in one go without getting breathless or feeling tightness in your chest?	☐ yes	☐ no
Do you sometimes feel tightness or a squeezing sensation in your chest?	☐ yes	☐ no

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Do you get short of breath during daily physical exertion?	☐ yes	☐ no
Blood / Blood clotting:		
Blood disease (e.g. leukaemia, anaemia)	☐ yes	☐ no
Blood clotting disorders (e.g. prolonged bleeding, tendency to bruise, tendency to thromboses)	☐ yes	☐ no
Are you taking blood-thinning medication?	☐ yes	☐ no
Gastrointestinal tract:		
Stomach problems (e.g. heartburn, reflux, gastric bypass, gastric band)	☐ yes	☐ no
Chronic bowel diseases (e.g. Crohn's disease, ulcerative colitis)	☐ yes	☐ no
Liver:		
Liver disease (e.g. hepatitis, cirrhosis of the liver)	☐ yes	☐ no
Kidneys:		
Impaired kidney function or kidney disease	☐ yes	☐ no
Metabolism:		
Raised cholesterol	☐ yes	☐ no
Diabetes	☐ yes	☐ no
Thyroid disease (e.g. over-function or under-function)	☐ yes	☐ no
Are you on cortisone therapy?	☐ yes	☐ no
Sensory organs:		
Severe sight or hearing disorder	☐ yes	☐ no
Raised intraocular pressure	☐ yes	☐ no
Musculoskeletal system:		
Diseases of the musculoskeletal system (e.g. spinal damage, disk prolapse, arthritis, etc.)	☐ yes	☐ no
Muscle diseases / muscle weakness	☐ yes	☐ no
Miscellaneous:		
Have you been hospitalised outside Switzerland in the past 12 months?	☐ yes	☐ no
Cancer	☐ yes	☐ no
Are you currently pregnant?	☐ yes	☐ no
Do you have loose / defective teeth or dentures?	☐ yes	☐ no
Have you ever received blood transfusions?	☐ yes	☐ no
Chronic viral infections? (e.g. HIV)	☐ yes	☐ no
Are you regularly taking any medication (if so, please enter in the attached list of medications)	☐ yes	☐ no

Toxicants:
Do you smoke? If so, how many a day?

Do you drink alcohol? ☐ never ☐ occasionally ☐ regularly
If regularly, how much?

Do you consume recreational drugs? If so, which?

Allergies / Drug intolerances:
Which?

Medication/Substance	Reaction	When

Questions, comments:

_____
_____
_____

Date: **Signature:**