HIRSLANDEN
CLINIQUE DES GRANGETTES

OBSTETRICS RESERVATION
CHEMIN DES GRANGETTES 7
1224 CHÊNE-BOUGERIES
T +41 22 305 01 14
reservations.obstetrique.gr@hirslanden.ch
www.hirslanden.ch/grangettes

PRE-OPERATIVE MEDICAL OBSTETRICAL QUESTIONNAIRE

To complete yourself or with the aid of your attending doctor.
When replying 'yes' to a question that mentions several situations, please circle those that concern you.

Name: Date of birth:

First name: Profession:

Weight: Height:

1. PREVIOUS OPERATIONS AND TYPE OF ANAESTHETIC

A = general anaesthetic, B = epidural or spinal anaesthetic, C = local anaesthetic (please tick):

1) ☐ A ☐ B ☐ C year: Clinic/Hospital:

2) ☐ A ☐ B ☐ C year: Clinic/Hospital:

3) ☐ A ☐ B ☐ C year: Clinic/Hospital:

4) ☐ A ☐ B ☐ C year: Clinic/Hospital:

a. Were there any incidents during the anaesthesia? ☐ Yes ☐ No ☐ Do not know

(nausea, vomiting, waking difficulties, other)?

If yes, during which type of anaesthesia? ☐ A ☐ B ☐ C

b. Have any of your family members experienced any anaesthesia incidents? ☐ Yes ☐ No ☐ Do not know

c. Have you previously had a blood transfusion? ☐ Yes ☐ No ☐ Do not know

2. HEART AND BLOOD VESSELS

a. Do you have/have you had any cardiac problems? ☐ Yes ☐ No
b. Can you walk up two floors without becoming breathless? ☐ Yes ☐ No
c. Do you have pain in your chest? ☐ Yes ☐ No
d. Do you have heart palpitations or does your heart beat too fast and/or irregularly? ☐ Yes ☐ No
e. Do you have a heart murmur? ☐ Yes ☐ No
f. Do you have high blood pressure? ☐ Yes ☐ No
g. If yes to the above, are you being treated for this? ☐ Yes ☐ No
h. Have you ever experienced a sudden loss of consciousness? ☐ Yes ☐ No
i. Do you have varicose veins? ☐ Yes ☐ No
j. Have you suffered from thrombophlebitis or a pulmonary embolism? ☐ Yes ☐ No
k. Do you have a pacemaker or a defibrillator? ☐ Yes ☐ No

3. LUNGS

a. Do you have/have you had a respiratory illness? ☐ Yes ☐ No
b. Do you have/have you had asthma? ☐ Yes ☐ No
c. Do you cough or spit every day? ☐ Yes ☐ No
d. Do you have symptoms of sleep apnea? ☐ Yes ☐ No
e. If yes to the above, do you have a device to alleviate sleep apnea? ☐ Yes ☐ No
f. Do you need oxygen at home? ☐ Yes ☐ No

4. NERVES, MUSCLES, BONES AND SKELETON

a. Have you had convulsions or epilepsy? ☐ Yes ☐ No
b. Have you had a cerebral stroke, a coma or cranial trauma? ☐ Yes ☐ No
c. If yes to the above, have you experienced paralysis, hemiplegia or paraplegia as a result? ☐ Yes ☐ No
d. Do you have severe migraines (headaches)? ☐ Yes ☐ No
e. Do you have a muscle disease (myopathy, myasthenia, etc.)? ☐ Yes ☐ No
f. Do you suffer from any spinal issues (malformation, fracture, herniated disc, etc.)? ☐ Yes ☐ No

If yes, please indicate:

g. Have you suffered from depression or severe anxiety? ☐ Yes ☐ No
h. Do you suffer from a rare disease? ☐ Yes ☐ No

If yes, please indicate:

5. DIGESTIVE SYSTEM

a. Do you have a hiatus hernia, an ulcer or heartburn? ☐ Yes ☐ No
b. Have you had jaundice or hepatitis? ☐ Yes ☐ No
c. Do you suffer from gall bladder or liver problems? ☐ Yes ☐ No

6. URINARY TRACT

a. Do you suffer from urinary infections or renal colics? ☐ Yes ☐ No
b. Do you have difficulties urinating and/or do you urinate several times a night? ☐ Yes ☐ No
c. Do you have kidney disease or renal insufficiency? ☐ Yes ☐ No

7. BLOOD AND COAGULATION

a. Do you have a blood disorder (thalassaemia, sickle cell disease, haemophilia, etc.)? ☐ Yes ☐ No
b. Have you or a member of your family experienced excessive bleeding after an injury, dental treatment or an operation? ☐ Yes ☐ No
c. Do you bruise frequently (haematoma)? ☐ Yes ☐ No
d. Does your nose bleed easily or when brushing your teeth? ☐ Yes ☐ No

8. METABOLIC DISEASE

a. Do you have thyroid problems or goitre? ☐ Yes ☐ No
b. Do you have cholesterol or gout? ☐ Yes ☐ No
c. Do you have diabetes? ☐ Yes ☐ No

If yes, indicate whether with or without insulin:

9. ALLERGIES

a. Do you have eczema, hives or hay fever? ☐ Yes ☐ No
b. Are you allergic to certain foods? ☐ Yes ☐ No

If yes, which foods?

c. Have you had angioedema (swelling of the face and throat)? ☐ Yes ☐ No
d. Are you allergic to:
- Iodized products (radiological, disinfectant, etc.)? ☐ Yes ☐ No
- Latex? ☐ Yes ☐ No
- Penicillin? ☐ Yes ☐ No
- Other antibiotics? ☐ Yes ☐ No
- Aspirin? ☐ Yes ☐ No

e. Are you allergic to other medication? ☐ Yes ☐ No

If yes, which medication?

10. VARIOUS QUESTIONS

a. Do you smoke? ☐ Yes ☐ No
If yes, how many per day? For how many years?

b. Do you drink alcohol? ☐ Yes ☐ No
If yes, how many glasses per day?
How many glasses of beer? How many glasses of wine? How many glasses of hard alcohol?

c. Do you take drugs (hashish, ecstasy, cocaine, heroin, other)? ☐ Yes ☐ No
d. Are you HIV positive or do you have hepatitis B or C? ☐ Yes ☐ No
e. Do you wear Prothesis,
(Dental prothesis: upper denture, lower denture, pivot teeth, etc.) ☐ Yes ☐ No
ocular prostheses (glasses or contact lenses) ☐ Yes ☐ No
or hearing aids? ☐ Yes ☐ No
f. Do you have glaucoma? ☐ Yes ☐ No
If yes, on which side?

g. Do you have damaged teeth? ☐ Yes ☐ No
h. Have you had a temperature during the last month? Shivers? Flu? A cold? ☐ Yes ☐ No
i. Is there any other information that you wish to indicate?

j. Will you accept a transfusion if absolutly necessery? ☐ Yes ☐ No

11. MEDICATION

a. Do you usually take aspirin or plavix? ☐ Yes ☐ No
b. Are you currently taking an anticoagulant
(Sintrom, Xarelto, Pradaxa, Eliquis, other)? ☐ Yes ☐ No
c. Has the discontinuation of you anticoagulant and its possible remplacement been scheduled? ☐ Yes ☐ No
d. Please indicate the name(s) and dosage(s) of your current medication
and enclose a copy of the prescription if possible:

Name and dosage of the medication	Morning	Noon	Evening	Night
Exemple : Dafalgan 1 g	1	0	1	0

Who can we contact if we need to? Name: Phone nr:

Name of your attending doctor/telephone number:

Other doctor/telephone number:

Date: Signature: _____

If you have completed this questionnaire with your attending doctor:

Date: Signature: _____

INFORMATION FOR ANAESTHESIA

To be signed before the anaesthesia consultation and sent to the obstetrical secretariat (by email reservations.obstetrique.gr@hirslanden.ch or post Clinique des Grangettes, Réservation Obstétrique, Chemin des Grangettes 7, 1224 Chêne-Bougeries) along with your completed questionnaire.

I, the undersigned _____ (first name and surname in capital letters) declare that I have read and understood the enclosed information document.

Geneva, on _____ Signature : _____

INFORMED CONSENT

I, the undersigned _____ (first name and surname in capital letters) declare that I have read the information documents received and have the necessary information for my anesthesia.

Specific remarks:

☐ I certify that I have been able to pose all my questions and that the anaesthetist has responded fully to these.

☐ **Billing:** I authorize my anesthesiologist to delegate the processing of my invoices and to electronically transfer them to the statistical trust center of the AMGe (Association of Physicians of Geneva). I also authorize my physician to proceed with the collection of my invoices by any appropriate means and legal channels, and I release them from professional confidentiality for this purpose.

Documentation provided: Brochure « Information about anaesthesia » and access to the website.

Geneva, on _____ Signature of the patient*: _____

or signature of the legal representative*: _____

*The signature of the patient must be obtained, except in case of emergency or incapacity of judgement.
This document must be part of the patient's file.
A copy may be given to the patient at his/her request.