ANAESTHESIA QUESTIONNAIRE

HIRSLANDEN

BC_e-2 OP – Einwilligung

ST_15 – ANA Fragebogen

Please return the questionnaire as soon as possible to:

Klinik Hirslanden
Institute for Anaesthesiology and Intensive Medicine (IFAI)
Witellikerstrasse 40
8032 Zurich

Telephone 044 387 22 99 / Fax 044 387 38 85
anascanning.hirslanden@hirslanden.ch

PERSONAL DETAILS

Family name	Date of birth
First name	Telephone Private
Address	Telephone Business
Zip code/City	Email address
Who is your family doctor (name, address, telephone number)?	

PLANNED SURGERY

You will undergo surgery on your...?	Date
your surgeons name is...	
Do you have a patient decree? ☐ Yes ☐ No	

PREVIOUS SURGERY

What type?	When?
What type?	When?
What type?	When?
What type?	When?
Have you or any of your close relatives ever had anaesthesia-related issues? If yes, what type?	

CURRENT STATE OF HEALTH

Have you ever had/do you have one or more of the following health issues?

Cardiac arrhythmia	☐ Yes	☐ No
Coronary artery disease (angina pectoris, heart attack)	☐ Yes	☐ No
Valvular heart disease	☐ Yes	☐ No
Pulmonary disease (e.g. COPD, asthma, etc.)	☐ Yes	☐ No
Pulmonary embolism	☐ Yes	☐ No
Stroke (brain haemorrhage or cerebral infarction)	☐ Yes	☐ No
Anticoagulation disease	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Insulin-dependent diabetes	☐ Yes	☐ No
Diabetes without insulin treatment	☐ Yes	☐ No
Have you ever been diagnosed with anaemia?	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Thyroid disease and other metabolic disorders	☐ Yes	☐ No
Neurological disease	☐ Yes	☐ No
Mental illness	☐ Yes	☐ No
Sleep apnoea	☐ Yes	☐ No
Do you have any allergies? If so, what type?	☐ Yes	☐ No
Muscle disease	☐ Yes	☐ No
Stomach issues (reflux, heartburn)	☐ Yes	☐ No

FITNESS

Can you climb two flights of stairs without experiencing breathing difficulties?	☐ Yes	☐ No
Do you have difficulty breathing during everyday activities?	☐ Yes	☐ No
Do you sometimes experience pain, a feeling of pressure or tightness in your chest?	☐ Yes	☐ No

GENERAL QUESTIONS

Are you pregnant?	☐ Yes	☐ No
Do you have a cardiac pacemaker or defibrillator?	☐ Yes	☐ No
Do you take blood-thinning medication?	☐ Yes	☐ No
Would you refuse life-saving blood products if you ever suffered life-threatening blood loss?	☐ Yes	☐ No

REMARKS

MEDICATION

What medication are you currently taking?

Name(s)	Dose

If you have crossed at least one red field or 2 blue fields and/or are over 65 years old and/or fall into operation risk class B or higher, you must undergo an evaluation from your family doctor before the surgery.

Date	Signature