HEALTH QUESTIONNAIRE

HIRSLANDEN

Please return the questionnaire as soon as possible:
- By e-mail to narkose@hirslanden.ch
- By post to: Klinik Hirslanden
Institut für Anästhesiologie und Intensivmedizin (IFAI)
Witellikerstrasse 40
8032 Zürich
T +41 44 387 21 66

PERSONAL DETAILS

Family name	Date of birth
First name	Telephone
Address	Mobile
Postcode/City	Email address
Occupation	Height (cm) Weight (kg)
Your family doctor (name, address, phone number, email)?	

PLANNED SURGERY

What surgery will be performed?	Date of surgery:
Name of the doctor performing the surgery?	

PREVIOUS SURGERY

What type? When?		
Have you or any of your close relatives ever had anaesthesia-related issues? If yes, what type?		
Do you have a history of delirium / confusion after surgery or any severe medical illness?	☐ Yes	☐ No

CURRENT STATE OF HEALTH

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

Cardiovascular diseases (e.g. angina pectoris, heart attack, stents)	☐ yes	☐ no
Heart failure (cardiac insufficiency)	☐ yes	☐ no
Diseases affecting the heart valves	☐ yes	☐ no
Cardiac arrhythmias	☐ yes	☐ no
Do you have a cardiac pacemaker or defibrillator?	☐ yes	☐ no
High blood pressure (please also tick if well-controlled by medication)	☐ yes	☐ no
Lung disease (e.g. COPD, asthma, home oxygen)	☐ yes	☐ no
Pulmonary embolism and/or thrombosis	☐ yes	☐ no
Stroke (cerebral haemorrhage or cerebral infarction)	☐ yes	☐ no
Blood diseases or blood clotting disorders (bleeding after dental treatment, surgery, menstruation)	☐ yes	☐ no
Do you take blood-thinning medication?	☐ yes	☐ no
Have you been diagnosed with anaemia?	☐ yes	☐ no
Renal disease	☐ yes	☐ no
Insulin-dependent diabetes (insulin pump yes / no?)	☐ yes	☐ no
Insulin-independent diabetes	☐ yes	☐ no
Stomach issues (reflux, heartburn, stomach bypass, gastric band)	☐ yes	☐ no
Liver disease	☐ yes	☐ no
Metabolic disorder (e.g. thyroid gland, cholesterol, uric acid)	☐ yes	☐ no
Neurological disease (e.g. epilepsy, Parkinson's, paralysis, neurostimulator)	☐ yes	☐ no

Cognitive impairment, recent decline in memory; confusion; severe auditory or visual impairment	☐ yes	☐ no
Serious muscle disease (e.g. myopathy, muscular dystrophy)	☐ yes	☐ no
Mental illness (e.g. depression, panic attacks, burnout)	☐ yes	☐ no
Breathing stops, sleep apnoea syndrome, nocturnal breathing aid (Please bring your therapy device to the clinic!)	☐ yes	☐ no
Allergy or intolerance (if yes, which?)	☐ yes	☐ no

PERFORMANCE

Do you have difficulty breathing during everyday activities?	☐ yes	☐ no
Do you have difficulty breathing when you climb two flights of stairs?	☐ yes	☐ no
Do you sometimes experience pain, a feeling of pressure or tightness in your chest?	☐ yes	☐ no

GENERAL QUESTIONS

Is there a chance that you are pregnant?	☐ yes*	☐ no
Were you hospitalised abroad during the past six months?	☐ yes	☐ no
Are you being or have you been treated for cancer? Of which organ?	☐ yes	☐ no
Do you have a advance directive?	☐ yes	☐ no
Do you refuse life-saving blood products in the event of a life-threatening haemorrhage?	☐ yes	☐ no
Do you smoke? If yes, how much per day: For how many years?	☐ yes	☐ no
Do you drink alcohol? If yes, how much per day:	☐ yes	☐ no
Did/do you take drugs? If yes, which drugs?	☐ yes	☐ no
Do you have loose or defective teeth?	☐ yes	☐ no

* If the surgical procedure is related to pregnancy (e.g. caesarian section, dilation and curettage, cerclage), no report from the family doctor is needed. Instead, please enclose any gynaecological reports you may have (laboratory, etc.).

REMARKS

MEDICATION

What medication are you currently taking? **When do you take it?**

Medication mg	Morning	Noon	Evening	Night

Date	Signature

Note for sending by e-mail:
Please save the form locally on your server first and then send it by e-mail to narkose@hirslanden.ch

If you have any questions about the completion of the questionnaire, please contact:
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