hirslanden
Klinik Hirslanden

ANAESTHESIA QUESTIONNAIRE

Please mark X, underline as applicable or complete.

PERSONAL INFORMATION

Last name	Date of birth	
First name	Telephone private	
Address	Telephone business	
Postcode/Place	Height	Weight

PLANNED OPERATION

Which operation?	Date of operation
Who is the surgeon?	
Who is your general practitioner?	
Address	

PREVIOUS OPERATIONS

		Kind of anaesthesia:
Which?	When:	☐ general ☐ local
Which?	When:	☐ general ☐ local
Which?	When:	☐ general ☐ local
Which?	When:	☐ general ☐ local

Did you suffer from complications from an anaesthesia? ☐ yes ☐ no

☐ vomiting ☐ nausea ☐ throat pains and swallowing difficulties ☐ headache ☐ dizziness ☐ breathing difficulties

Have any blood relatives had complications related to an anaesthesia? ☐ yes ☐ no

If yes, which?

Have you had a check-up within the last 12 months? ☐ yes ☐ no

If yes, who was the physician?
Name / address

GENERAL QUESTIONS

Have you been in a physician's care recently? ☐ yes ☐ no Why?

Do you smoke regularly? ☐ yes ☐ no How much?

Do you drink alcohol on a regular basis? ☐ yes ☐ no How much?

Did or do you take drugs? ☐ yes ☐ no Which?

Are you pregnant? ☐ yes ☐ no

Have you ever had a blood transfusion? ☐ yes ☐ no

Did you show any abnormal or unusual reaction to the transfusion? ☐ yes ☐ no

Do you wear dentures? (crowns, dental bridges, removable dentures) ☐ yes ☐ no

Do you have loose teeth? ☐ yes ☐ no

Do you wear a hearing aid? ☐ yes ☐ no

Do you have a cardiac pacemaker or a defibrillator? ☐ yes ☐ no
Please bring the related document with you for the operation

Do you have a piercing? ☐ yes ☐ no

QUESTIONS ABOUT YOUR GENERAL HEALTH

Are you able to look after your personal hygiene without assistance? ☐ yes ☐ no

Can you walk a distance of around 500 meters on flat ground? ☐ yes ☐ no

Are you able to carry out light housework tasks? ☐ yes ☐ no

Are you able to climb 1-2 floor levels? ☐ yes ☐ no

Are you able to participate in easy kinds of sport (cycling, hiking)? ☐ yes ☐ no

Do you have difficulty in breathing on a daily basis? ☐ yes ☐ no | When yes, by which activities?

Do you suffer heart problems on a daily basis? ☐ yes ☐ no

HAVE YOU SUFFERED ANY COMPLAINTS IN CONNECTION WITH THE FOLLOWING?

Heart (Heart attack, angina pectoris, cardiac defect) ☐ yes ☐ no

Blood pressure (High blood pressure, low blood pressure) ☐ yes ☐ no

Vascular ailments (Circulation disturbances, varicose veins, thromboses) ☐ yes ☐ no

Lungs and respiratory tract (Asthma, chronic bronchitis, pulmonary emphysema, Pneumonia, pulmonary embolism, cough) ☐ yes ☐ no

Esophagus, stomach, bowels (Heartburn, frequent vomiting, ulcer, digestive problems) ☐ yes ☐ no

Kidneys and urinary track (Kidney stones, inflammation of kidney, high kidney readings, dialysis, cystitis) ☐ yes ☐ no

Metabolism (Diabetes, gout, high blood-fat) ☐ yes ☐ no

Eyes (Glaucoma, lens turbidity, pupil difference, impaired vision, sight defect) ☐ yes ☐ no

Musculoskeletal system (Arthropathy, back problems, postural defmity, shoulder or arm pains) ☐ yes ☐ no

Have you or any blood relatives suffered from muscle diseases? ☐ yes ☐ no

Blood (Anemia, blood cancer, leukemia) ☐ yes ☐ no

Coagulation disorders (frequent nose bleeds and bleeding gums, lengthy bleeding following an accident /birth/operation, easy bruising) ☐ yes ☐ no

Medicaments for the thinning of the blood? ☐ yes ☐ no

Nerves (Cerebral apoplexy, epilepsy, paralysis, forgetfulness, lack of concentration, headache, migraine) ☐ yes ☐ no

Do you have allergies (Hay fever, asthma, hypersensitivity to certain foods, medications, latex, adhesive tapes, iodine, contrast agents, cosmetics, metals) ☐ yes ☐ no

Are you taking medication at the moment? ☐ yes ☐ no

Name	How much
Name	How much
Name	How much
Name	How much

TO BE FILLED IN BY THE ANAESTHESIST / VOM ANÄSTHESIEARZT AUSZUFÜLLEN

Anzahl MET ☐ <4 ☐ 4–6 ☐ >6 | Risikoklasse Operation ☐ A ☐ B ☐ C

Bericht nötig ☐ ja ☐ nein | Bericht geplant ☐ ja ☐ nein

Spezielle Untersuchungen? ☐ ja ☐ nein | Nüchterneintritt möglich? ☐ ja ☐ nein

Datum	Kürzel