KLINIK ST. ANNA
ST. ANNA IN MEGGEN
ST. ANNA IM BAHNHOF

HIRSLANDEN

DOCUMENTS TO BE SENT BY THE SURGEON

- Email: patientendisposition.stanna@hirslanden.ch
- Via Doc Box

HEALTH QUESTIONNAIRE

PERSONAL DETAILS

Surname	Date of birth
First name	Telephone
Address	Mobile
Postcode/city	**Height (cm)**
Profession	**Weight (kg)**
Your family doctor (name, place)	

PLANNED SURGERY

What surgery will be performed?	Date:

PREVIOUS SURGERIES

Have you ever had problems with anaesthesia during previous surgeries? If yes, which problems:	☐ Yes	☐ No
Were there ever complications with previous surgeries? If yes, which complications:	☐ Yes	☐ No
Have you previously experienced an acute confusional state (delirium) after surgery performed as a result of a serious illness?	☐ Yes	☐ No

STATE OF HEALTH

Performance

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

Have you ever had or do you have one or more of the following problems?

Heart disease (e.g., angina pectoris, heart attack, stents, cardiac insufficiency, valve disease, status post heart surgery)	☐ Yes	☐ No
Cardiac arrhythmias (atrial fibrillation, pacemaker or defibrillator fitted)	☐ Yes	☐ No
High blood pressure (please also tick if well controlled by medication)	☐ Yes	☐ No
Lung disease (e.g., COPD, asthma, home oxygen, pulmonary embolism)	☐ Yes	☐ No
Sleep apnoea (please bring your therapy device to the hospital)	☐ Yes	☐ No
Stroke (cerebral haemorrhage or cerebral infarction)	☐ Yes	☐ No
Blood disorders or blood-clotting disorders (e.g., thrombosis, bleeding after dental treatment, surgery, menstruation)	☐ Yes	☐ No
Have you been diagnosed with anaemia?	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Diabetes or metabolic disorder (e.g., thyroid gland, cholesterol, uric acid)	☐ Yes	☐ No
Liver disease or jaundice	☐ Yes	☐ No
Stomach issues (e.g., reflux, heartburn, gastric bypass, gastric band)	☐ Yes	☐ No

Neurological disorder (e.g., epilepsy, Parkinson's, paralysis, neurostimulator)	☐ Yes	☐ No
Memory disorder, development of dementia, confusion, severe visual or hearing impairment	☐ Yes	☐ No
Serious muscle disease (e.g., myopathy, muscular dystrophy)	☐ Yes	☐ No
Mental illness (e.g., depression, panic attacks, burnout)	☐ Yes	☐ No
Is there a chance that you are pregnant?	☐ Yes	☐ No
Do you currently have cancer? If yes, which one:	☐ Yes	☐ No
Would you refuse life-saving blood products in the event of life-threatening bleeding?	☐ Yes	☐ No
Allergy or intolerance? (Please bring your allergy pass with you to the hospital) If yes, which: What type of reaction:	☐ Yes	☐ No
Do you drink spirits, wine or beer daily?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Did/do you take drugs? If yes, which:	☐ Yes	☐ No

MEDICATION

Do you take any blood-thinning medication? If yes, which:	☐ Yes	☐ No
Do you take any other medication?	☐ Yes	☐ No

If yes, which medication?			When do you take it?			
Medication	Manufacturer	Dose	Morning	Noon	Evening	Night

(If you take more than three medications, please attach an up-to-date list of medications)

REMARKS

Date: _____ Patient's signature: _____

(Not required when sending electronically.)

TO BE COMPLETED BY THE MEDICAL PROFESSIONAL PROVIDING TREATMENT

The patient needs a preoperative examination by the family doctor:	☐ Yes	☐ No
Is patient blood management required (anaemia)?	☐ Yes	☐ No

Date:	Surgeon's contact details:

An examination by the family doctor is compulsory if:

- at least **one red field or two blue fields** have been ticked,
- the patient is **over the age of 70**,
- the intervention falls under **risk class B or C**.

If you have any questions about completing the health questionnaire, please contact:

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Email: kais@hirslanden.ch

SEND