

## Anaesthesia questionnaire

Please complete this questionnaire and return it by mail or email as soon as possible.

Postal address: Spital Männedorf AG, Patienten-Aufnahme, Asylstrasse 10, 8708 Männedorf

email: [eintritt@spitalmaennedorf.ch](mailto:eintritt@spitalmaennedorf.ch)

### Personal information

Surname \_\_\_\_\_ Date of birth \_\_\_\_\_

First name \_\_\_\_\_ Private phone number \_\_\_\_\_

email \_\_\_\_\_ Mobile phone number \_\_\_\_\_

### Are you under the care of a general practitioner (GP) or cardiologist? When was the last checkup?

GP \_\_\_\_\_

Cardiologist \_\_\_\_\_

### What medication are you taking? (Name/dose)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Previous operations/anaesthesia

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Do you have or have you ever had any of the following conditions? If yes, please add a comment.

Anaesthesia problems experience by you or relatives, e.g. malignant hyperthermia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart condition: e.g. heart attack, stents, arrhythmias, atrial fibrillation, heart valves	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Pacemaker	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Please bring the Pacemaker ID card
High blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you take any blood-thinning medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Coagulation disorder: e.g. frequent bruising, nosebleeds or bleeding gums	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Lung condition: e.g. COPD, asthma, home oxygen therapy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Thrombosis, pulmonary embolism	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stroke, cerebral haemorrhage	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Kidney disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes



Elevated blood sugar or diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stomach condition: e.g. acid reflux, hiatus hernia, stomach operation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Liver disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anaemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Muscular disorders or muscular atrophy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Back pain or slipped disc	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nervous system: epilepsy, paralysis, sensory disturbance, Parkinson's disease, chronic pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Thyroid condition: overactive or underactive thyroid, other metabolic disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sleep apnoea	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Bring your therapy device on the day of the surgery
Mental illness: e.g. depression, claustrophobia, panic attacks	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Infectious diseases: HIV, tuberculosis, hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes

### General questions

**Height:** \_\_\_\_\_ **cm**      **Weight:** \_\_\_\_\_ **kg**      (important for calculating the medication dosage)

Can you climb two flights of stairs without getting short of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience shortness of breath or feel pressure in your chest in your day-to-day life?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have any allergies (e.g. to latex, iodine, medication, disinfectant)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you pregnant or breastfeeding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have removable dentures or loose teeth?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you drink alcohol several times a week?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: how much?
Do you smoke?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: how much?
Do you take drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: which?
Do you have a living will?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Please bring a copy

### Additional information/questions:

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Date: \_\_\_\_\_ Patient's signature: \_\_\_\_\_