Stadtspital Zürich

Anaesthesia health questionnaire for adults

1. Personal details

Last name

First name

Date of birth

Height (cm)

Weight (kg)

2. Have you ever been in a hospital due to health problems/medical procedures?

Yes **No**

If so, when?	If so, where?	If so, why?

3. Have you or any blood relations ever experienced any problems or incidents during surgery or anaesthesia?

Yes **No**

If so, which? Please explain:

Please also complete pages 2 and 3.

4. Ability to function

Can you walk up two flights of stairs without breathing difficulties?	Yes	No
Do you do your shopping and household chores independently?	Yes	No
Do you sometimes have pain, a feeling of pressure or tightening in your chest?	Yes	No
Can you lie flat?	Yes	No

5. Do you have any allergies?

Yes **No**

If so, which?

6. What medication are you taking? (Please specify exact dosage)

None

Medication	mg	Morning	Midday	Evening	Night

Please also complete pages 1 and 3.

7. Do you suffer or have you ever suffered from one or more of the following health problems?

High blood pressure (also mark with an 'X' if well managed by medication)	Yes	No
Cardiovascular diseases (e.g. heart attack, stents, angina pectoris)	Yes	No
Cardiac insufficiency (heart failure)	Yes	No
Cardiac arrhythmia (e.g. atrial fibrillation)	Yes	No
Do you have a pacemaker/defibrillator? (ICD)	Yes	No
Lung diseases (e.g. COPD, asthma, home oxygen therapy, emphysema, fibrosis)	Yes	No
Pulmonary embolism and/or thrombosis (legs, arms)	Yes	No
Stroke (cerebral haemorrhage, cerebral infarction)	Yes	No
Blood disorders, coagulation disorders (postoperative haemorrhage)	Yes	No
Anaemia	Yes	No
Are you prone to bruising? (Haematoma, including the torso)	Yes	No
Kidney disease (e.g. renal failure, dialysis)	Yes	No
Liver disease (e.g., cirrhosis, fatty liver, hepatitis)	Yes	No
Bowel disease (e.g. Crohn's disease, ulcerative colitis, irritable bowel syndrome)	Yes	No
Stomach disease (gastritis, diaphragmatic hernia, gastric bypass)	Yes	No
Do you suffer from acid reflux? (heartburn)	Yes	No
Metabolic disease (e.g. obesity, cholesterol, uric acid)	Yes	No
Diabetes (pre-diabetes, type-1 and type-2 diabetes)	Yes	No
Neurological disease (e.g. Parkinson's disease, epilepsy, paralysis, dizziness)	Yes	No
Muscle diseases (e.g. muscular dystrophy, myopathy, myasthenia gravis)	Yes	No
Thyroid disease (overactive or underactive, goitre)	Yes	No
Mental illness (depression, panic attacks, claustrophobia, burnout)	Yes	No
Sleep apnoea (please bring therapy device (CPAP) to the hospital)	Yes	No
Do you wear dental prostheses?	Yes	No
Are any of your teeth loose or defective?	Yes	No
Do you smoke? If so, how many per day: For how many years:	Yes	No
Do you drink alcohol? If so, how much per day:	Yes	No
Do you take/have you ever taken drugs? If so, which:	Yes	No
Are you/have you ever been treated for cancer? If so, which organ?	Yes	No
For women: could you be pregnant?	Yes	No
Do you suffer from any other health problems not listed above? If so, which?	Yes	No

I hereby declare that the information I have provided is correct:

Place, date	Signature of patient

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