ANÄSTHESIE SEEFELD

Anesthesia questionnaire

Please fill in the front and back, mark with a cross accordingly and underline or mention what applies

Laste Name ..... **To be filled in by the anesthesiologist**

First name..... ☐ No report required

Date of birth ..... ☐ Visum

Height..... cm Weight .....kg Date: ..... Initials: .....

Planned operation

Which operation is planned? .....

Which doctor will operate on you .....

Date of the planned operation? .....

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

If yes, with which doctor .....

Previous operations

Type of anesthesia

When? ..... ☐ General

Which one? . ..... ☐ Partial

When? ..... ☐ General

Which one? ..... ☐ Partial

When? ..... ☐ General

Which one ? ..... ☐ Partial

Did any incidents occur during anesthesia? ☐ yes ☐ no

If so, which ones? .....

Did you experience discomfort? ☐ yes ☐ no

Nausea, vomiting, dizziness, shivering, breathing difficulties, swallowing difficulties

Other? .....

Anesthesia incidents with blood relatives? ☐ yes ☐ no

If so, which ones? .....

General questions

Have you had medical treatment recently? ☐ yes ☐ no

If so, why? .....

Do you smoke regularly ☐ yes ☐ no

If so, how much? .....

Do you drink alcohol regularly? ☐ yes ☐ no

If so, how much? .....

Do you take drugs? ☐ yes ☐ no

If so, which ones? .....

Could there be a pregnancy ? ☐ yes ☐ no

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

In the last 3 months ☐ yes ☐ no

Do you wear dentures ☐ yes ☐ no

Removable prosthesis, post tooth, jacket crown

Do you have loose teeth? ☐ yes ☐ no

Do you wear hearing aids? ☐ yes ☐ no

Do you have a pacemaker or defibrillator? ☐ yes ☐ no

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Have you been or are you ill in the following organ systems?

Mark accordingly and underline as appropriate

Heart ☐ yes ☐ no

Heart attack, angina pectoris, heart defect, stent, bypass, arrhythmia, inflammation of the heartmuscle shortness of breath on exertion or when lying flat

or .....

Circulation ☐ yes ☐ no

High blood pressure

low blood pressure

or .....

Vessels ☐ yes ☐ no

Circulatory disorders, varicose veins Thromboses

or .....

Lungs and airways ☐ yes ☐ no

Pneumonia, tuberculosis, asthma, emphysema chronic bronchitis, pulmonary embolism, cough/expectoration, sleep apnea

or .....

Esophagus, stomach, intestines, liver, gallbladder ☐ yes ☐ no

heartburn frequent vomiting, ulcer, reflux digestive problems, gallstones, hepatitis

or .....

Metabolism ☐ yes ☐ no

Diabetes, gout, elevated blood lipids

or……

Thyroid gland ☐ yes ☐ no

Hyperfunction or underfunction

or .....

Kidneys and urinary tract ☐ yes ☐ no

Kidney stones, inflammation, elevated kidney values, dialysis, bladder infections

or .....

Musculoskeletal system ☐ yes ☐ no

Joint disease, back pain, shoulder or arm pain

or

Blood

Blood clotting disorder, (nosebleeds or bleeding gums, hematoma, anemia, very heavy menstrual bleeding

Nerves

Stroke, seizure disorders (epilepsy), paralysis, sensory disturbances, forgetfulness, poor concentration, headaches, migraines

or .....

Psyche ☐ yes ☐ no

depression, anxiety disorder

or .....

Allergy ☐ yes ☐ no

Hay fever, asthma, hypersensitivity to medication, latex, food, iodine, adhesive plasters, contrast agents, cosmetics, metals

or .....

Are you currently taking any medication? ☐ yes ☐ no

Please enclose a list of medications if available

Which ones ? .....

.....

.....

Other diseases not listed

……..

.....

.....

Preliminary telephone consultation with anesthesiologist requested ☐ yes ☐ no

Telephone number.....

I hereby confirm that I have filled in all information truthfully, and that I have read the anesthesia questionair.

I am informed that I can discuss the anesthesia in advance by telephone or in person. On the day of admission, the anesthesiologist in charge will have a personal conversation with me.

Place……

Date…….....

Signature……..

Notes : (to be completed by anesthesiologist)

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Please mail this questionnaire as soon as possible to: info@narkose-seefeld.ch

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