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Health questionnaire

Information about the operation			
Operation		Procedure date	
Operating surgeon		Procedure duration	
Information about the patient			
Surname	First name	☐ Male ☐ Female	Date of birth
Address		Location / postal code	
Tel P		Mobile	
Email		Pension insurance no.	
If the patient is a minor, name and first name of the parents			
Name and telephone no. of the legal representative (guardian)			
Name, address and telephone no. of the family doctor			
☐ I understand German (If no, please bring an interpreter with you)			
☐ I have a patient decree (please bring this with you on the day of the operation)			
☐ I have orders for resuscitation (please bring this with you on the day of the operation)			
Size		**Weight**	
Allergies Intolerances			

Have you received medical treatment in recent weeks? If so, for what reason?	☐ YES	☐ NO
Have you ever had an operation? If so, for what reason?	☐ YES	☐ NO
Is there a congenital defect or disability? If yes, what?	☐ YES	☐ NO
Have you experienced any exceptional occurrences during anaesthesia? If yes, please give details.	☐ YES	☐ NO
Have you suffered from ☐ nausea / ☐ vomiting after anaesthesia?	☐ YES	☐ NO
Have there been any exceptional occurrences when relatives were anaesthetised? If yes, please give details.	☐ YES	☐ NO
Do you have a ☐ cold or a ☐ fever?	☐ YES	☐ NO
Do you have any other infection(s)? ☐ HIV ☐ Hepatitis If yes, please give details.	☐ YES	☐ NO
Have you ever had a blood transfusion?	☐ YES	☐ NO
Could you be pregnant?	☐ YES	☐ NO
Can you climb 2 floors of stairs without stopping?	☐ YES	☐ NO
Cardiovascular disease: ☐ High blood pressure ☐ Coronary arteries ☐ Heart valves ☐ Arrhythmias Other:	☐ YES	☐ NO

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Blood vessel disease: ☐ Varicose veins ☐ Thrombosis ☐ Stroke	☐ YES	☐ NO
Blood Clotting Disorders	☐ YES	☐ NO
Lungs & airways: ☐ Asthma ☐ Chronic bronchitis ☐ Sleep apnea If so → do you have a CPAP device? ☐ yes ☐ no	☐ YES	☐ NO
Liver: ☐ Hepatitis Other:	☐ YES	☐ NO
Gastrointestinal or oesophagus: ☐ Reflux/acid regurgitation Other:	☐ YES	☐ NO
Kidneys: Elevated kidney values? Other:	☐ YES	☐ NO
Metabolism: Diabetes ☐ insulin-dependent ☐ Diet/medication Thyroid ☐ Hyperfunction ☐ Hypofunction	☐ YES	☐ NO
Muscle deseases:	☐ YES	☐ NO
Skeletal system: Joint disease or problems with the cervical vertebrae	☐ YES	☐ NO
Nervous system: ☐ Seizures (epilepsy) ☐ Migraines ☐ Depression	☐ YES	☐ NO
Do you wear dentures or have loose teeth?	☐ YES	☐ NO
Do you consume alcohol or nicotine regularly?	☐ YES	☐ NO
Do you use drugs?	☐ YES	☐ NO
Do you take anticoagulant medication? If yes, please give details.	☐ YES	☐ NO
Do you take other medications? If yes, please give details.	☐ YES	☐ NO
Remarks		

Date: _____ Signature: ..... (not required for direct e-mail dispatch)

Please also take note of our patient information leaflets:
https://narkose.ch/en/info-brochure/
I confirm that I have completed this form for recording my medical history to the best of my knowledge, completely and truthfully, and that I have read and understood the information leaflets.
Please send us this form

- Via e-mail: info-winterthur@narkose.ch (HIN-protected address)
- By post to: Einsatzplanung narkose.ch, Riedhofstr. 67, 8408 Winterthur