ANESTHETIC QUESTIONNAIRE

KANTONSSPITAL OBWALDEN

Dear Patient,
To ensure that your anesthesia is as gentle and safe as possible, we kindly ask you to answer the following questions about your health/pre-existing conditions to the best of your knowledge. The anesthesiologist will discuss any remaining questions and the recommended anesthesia support with you in detail during your pre-anesthesia consultation.

First- and Last name / Date of birth _____

Current **Height** _____ **cm** Current **Weight** _____ **kg**

Do you suffer or have you suffered from any of the following conditions/symptoms?

Please tick/underline/note on the back as appropriate.					Yes	No
Allergies	e.g. reactions to medications, contrast agents, latex, foods, fruits (e.g., kiwi, pineapple), metals (e.g., nickel), or **severe side effects/adverse reactions to medications**. If so, which ones:				☐	☐
	Do you have an **allergy card**? Please send us a copy.				☐	☐
Heart	e.g. angina pectoris, heart attack, cardiac arrhythmias (atrial fibrillation), stent/bypass/heart valve/pacemaker/defibrillator implantation				☐	☐
Blood presure	☐ too high	☐ too low	☐ treated with medication		☐	☐
Capacity	**Shortness of breath/tightness in the chest** when climbing two flights of stairs or walking uphill				☐	☐
Lung	e.g. asthma, chronic bronchitis, COPD, home oxygen therapy				☐	☐
Sleepapnoe	OSAS	☐ with CPAP-device	☐ without CPAP-device		☐	☐
Liver	e.g. jaundice, liver cirrhosis, variceal bleeding				☐	☐
Kidneys	e.g. kidney failure, inflammation, kidney stones, dialysis				☐	☐
Gastrointestinal	e.g. stomach ulcer, acid reflux, vomiting, ulcerative colitis				☐	☐
Diabetes	☐ Typ 1	☐ Typ 2	☐ with insulin	☐ with tablets	☐	☐
Thyroid	e.g. goiter, over- or underactive thyroid				☐	☐
Nervous-system	e.g. epilepsy, paralysis, stroke, transient ischemic attack (TIA), dizziness				☐	☐
Muscles	e.g. muscle weakness, malignant hyperthermia, muscular dystrophy				☐	☐
Skeleton	e.g. herniated disc, spinal stenosis, osteoporosis, rheumatism				☐	☐
Vessels	e.g. peripheral arterial disease (PAD), vascular occlusion/aneurysm				☐	☐
Blood/ -coagulation	e.g. factor V Leiden, thrombosis, pulmonary embolism, von Willebrand disease, hemophilia, anemia				☐	☐
	Bleeding tendency, e.g. frequent unexplained bruising, nosebleeds or bleeding gums, postoperative/postnatal bleeding				☐	☐
	Have you ever had a coagulation test?				☐	☐
Infections	e.g. hepatitis B or C, HIV/AIDS, tuberculosis				☐	☐
Tumors	If yes: which, when, which therapy (surgery/chemotherapy/radiation)				☐	☐
Immune system	e.g. autoimmune disease, multiple sclerosis, myasthenia gravis				☐	☐
For women	Are you pregnant? If so: Which week of pregnancy ? When is your due date?				☐	☐

Please also fill out the back ⇨

Do you consume or have you regularly consumed:		Yes	No
Nicotine	If yes, how much per day and for how many years?	☐	☐
Alcohol	If yes, what type and how much per day/week?	☐	☐
Drugs	If yes, which ones and how often per day/week?	☐	☐

Have you or did you have:		Yes	No
Medications you take regularly? Please list your medications on this questionnaire / attach a **medication list**.		☐	☐
Blood thinning or antiplatelet medications? e.g. Aspirin, Xarelto/Rivaroxaban, Eliquis, Marcoumar. If yes, which ones?		☐	☐
Blood products, e.g. red blood cell concentrates, within the last 14 days?		☐	☐
Previous surgeries? If so, what surgery was performed/when:		☐	☐
Previous anesthetics? If so, what type of anesthesia did you have:	☐ General anesthesia ☐ Regional anesthesia	☐	☐
Problems during surgery or anesthesia? If so, what kind of problems occurred :		☐	☐
Dental problems: e.g. dentures (full/partial), loose teeth/wobbly teeth?		☐	☐
Hearing aids, contact lenses, piercings or **metal in the body?**		☐	☐
Inpatient hospital stays in the last 12 months? If so, why:		☐	☐
ECG/heart examinations in the last 6 months?		☐	☐
Laboratory/blood tests in the last 6 months?		☐	☐
Current medical treatments/therapies not related to the planned surgery? If so, which ones:		☐	☐
An **advance healthcare directive?** Please send us a copy.		☐	☐
Questions for the anesthesiologist? Anything else you would like to tell us beforehand?		☐	☐

Please confirm the accuracy of the above information with your signature.

Date/Signature: _____

Thank you for your cooperation!
Your safety is our highest priority – Your Anesthesia Team
✉ anaesthesie@ksow.ch / ☎ 041 666 40 72

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