KANTONSSPITAL OBWALDEN

Dear Patient,

You have scheduled an operation with anesthesia support at the Obwalden Cantonal Hospital.

We, the anesthesia team at the Obwalden Cantonal Hospital, look forward to supporting you during your procedure.

Whether you are scheduled for general anesthesia, regional anesthesia or surgery under local anesthesia with support from the anesthesia team (LA standby/sedation),
we require information about your health to ensure your safety.

Therefore, we ask you to complete the following questionnaire and then submit it to your surgeon's office/reception.

Important:

If you are unable to answer any questions or if anything is unclear, please simply leave the corresponding question unanswered.
We will discuss the questionnaire with you in detail during your pre-anesthesia consultation and clarify any uncertainties or open questions.

We look forward to welcoming you to the Obwalden Cantonal Hospital soon.

Your safety is our highest priority.

On behalf of the Anesthesia Team

Nadine Krumm
Head physician Anesthesia
Medical Directorate Anesthesia

Prof. Dr. med. Stefan Suttner
Chief physician Anesthesia
Obwalden Cantonal Hospital

You are welcome to keep this cover letter with your records.
If you have any questions, please feel free to contact us via ✉ anaesthesie@ksow.ch or
☎ 041 666 40 72

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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