*Spital Bülach*

Institute of Anaesthesiology

*Please return the completed questionnaire via email **or** post to:*
paps@spitalbuelach.ch
**or**
Spital Bülach AG, Sekretariat Anästhesie (PAPS)
Spitalstrasse 24
CH-8180 Bülach
Tel. +41 44 863 27 87

# Health Status Questionnaire

| **PATIENT DETAILS** | | |
|---|---|---|
| Surname, first name: | Address: | Job title: |
| Date of birth: | Email: | Tel: |

| | |
|---|---|
| Height: | Weight: |

| | |
|---|---|
| **What is being operated on?** | **Date of surgery:** |

| **PREVIOUS OPERATIONS** | | |
|---|---|---|
| What was the operation? When? | | |
| Have you or any blood relatives experienced any problems with anaesthesia?<br>If so, please specify: | □ yes | □ no |

| **FAMILY DOCTOR** | |
|---|---|
| Last name: | Tel: |
| Address: | Email: |

| **PHYSICAL CONDITION** | | |
|---|---|---|
| Can you climb two flights of steps without needing to take a break? | □ yes | □ no |
| Have you ever experienced chest pain/pressure? | □ yes | □ no |
| Do you experience shortness of breath in your day-to-day life? | □ yes | □ no |

| **HEALTH QUESTIONS** | | | |
|---|---|---|---|
| Have you had or do you have any of the following? | | | |
| Heart | Diseases of the coronary arteries (heart attack, angina pectoris, coronary artery disease (CAD))? | □ yes | □ no |
| | Heart failure? | □ yes | □ no |
| | A heart valve defect? | □ yes | □ no |
| | Cardiac arrhythmia (e.g. atrial fibrillation)? | □ yes | □ no |
| | Do you use a cardiac pacemaker (PM)/defibrillator (ICD)? | □ yes | □ no |

**PLEASE TURN OVER**

DT_SPB_6

| | | | |
|---|---|---|---|
| Coagulation | Blood diseases/blood clotting disorders, high tendency to bleed (e.g. bleeding after operations, frequent nosebleeds, prolonged menstruation)? | □ yes | □ no |
| | Do you take medication to thin your blood (e.g. aspirin, Plavix, Marcoumar, Xarelto, Eliquis)? | □ yes | □ no |
| Blood | Are you anaemic? | □ yes | □ no |
| Lungs | Lung diseases, e.g. obstructive sleep apnoea syndrome (OSAS), bronchial asthma, chronic bronchitis, COPD? | □ yes | □ no |
| Kidneys | Kidney diseases, e.g. renal insufficiency (kidney weakness, kidney failure)? | □ yes | □ no |
| Diabetes | Insulin-dependent diabetes (IDDM)? | □ yes | □ no |
| | - If yes: Do you have an insulin pump? | □ yes | □ no |
| | Non-insulin-dependent diabetes (NIDDM)? | □ yes | □ no |
| Neurology | Stroke (cerebral infarction or cerebral haemorrhage), epilepsy, paralysis, multiple sclerosis (MS), Parkinson's disease? | □ yes | □ no |
| Muscles | Do you or any of your blood relatives have a muscle disorder (e.g. myopathy, muscular dystrophy)? | □ yes | □ no |
| Liver | Liver diseases, e.g. hepatitis, liver cirrhosis (shrunken liver)? | □ yes | □ no |
| Stomach | Stomach ulcer, acid regurgitation, gastric bypass/gastric band? | □ yes | □ no |
| Metabolism | Thyroid disease (overactive, underactive), high cholesterol, high uric acid levels (gout)? | □ yes | □ no |
| Orientation | Memory impairment, dementia, confusion, severe hearing/visual impairment? | □ yes | □ no |
| Mind | Psychiatric disorders, e.g. depression, schizophrenia, anxiety disorder? | □ yes | □ no |
| Blood pressure | High blood pressure (please tick yes even if well regulated)? | □ yes | □ no |
| | Low blood pressure? | □ yes | □ no |

| **OTHER** | | | |
|---|---|---|---|
| Allergies | Do you have any allergies, e.g. to medication, iodine, latex, nickel?<br>If yes, please specify: _____ | □ yes | □ no |
| Pregnancy/ breastfeeding | Could you be pregnant? | □ yes | □ no |
| | Are you breastfeeding? | □ yes | □ no |
| Dental status | Do you wear removable dentures? | □ yes | □ no |
| | Do you have any loose or broken teeth? | □ yes | □ no |
| Nicotine | Do you smoke?<br>If yes, how many cigarettes a day? _____ How many years have you been smoking? _____ | □ yes | □ no |
| Alcohol | Do you drink alcohol?<br>If yes, how many units a day?_____ | □ yes | □ no |
| Drugs | Do you take/have you taken drugs?<br>If so, please specify: _____ | □ yes | □ no |
| Advance healthcare directive | Do you have an advance healthcare directive? (If yes, please enclose a copy.) | □ yes | □ no |
| Blood products | In the event of life-threatening bleeding, would you accept life-saving blood products? | □ yes | □ no |
| Cancer treatment | Are you being treated or have you ever been treated for cancer?<br>If yes, which organ is/was affected? _____ | □ yes | □ no |

| **MEDICATION** (or enclose list) | *mg* | Morning | Noon | Evening | Night |
|---|---|---|---|---|---|
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**Place, date:** **Signature of patient or their legal representative**