

## Health questionnaire for your child

Dear parents

Your child is scheduled for a treatment, examination or surgery under anesthesia. In order to be able to care for your child with the greatest possible safety and care, we need precise information about your child's state of health. Thank you for completing this questionnaire carefully and returning it to us promptly.

### PERSONAL DETAILS

Name (child):	First Name (child):	
Date of birth (child):	Height:	Weight:
Parent's First & Last Name	Mobile:	
Pediatrician (Name, place, phone number):		

SCHEDULED TREATMENT / SURGERY:	Date of intervention:
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PREVIOUS TREATMENTS /SURGERIES	YES	NO
Has your child already had an anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
If so, what kind of anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
Were there any issues during previous anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please precise:	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any problems with blood relatives in connection with anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please precise:	<input type="checkbox"/>	<input type="checkbox"/>

BIRTH / INFANCY	YES	NO
Is your child a premature baby?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, in which week of pregnancy birth was given?	<input type="checkbox"/>	<input type="checkbox"/>
Where the any problems in the first live period?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please precise	<input type="checkbox"/>	<input type="checkbox"/>

YOUR CHILD'S CURRENT STATE OF HEALTH	YES	NO
Is your child currently suffering a few?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have the impression that your child's physical performance is weaker than that of children of the same age?	<input type="checkbox"/>	<input type="checkbox"/>
Heart diseases (Heart defects, cardiac arrhythmia, heart surgery, heart murmur, heart valve disease)?	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure or circulatory problems?	<input type="checkbox"/>	<input type="checkbox"/>
Lung diseases (cystic fibrosis, asthma, bronchitis)?	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea / Cyanose (blue lips) during sport or physical exertion?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>
Diseases of the blood or blood clotting (e.g. leukemia, anemia, frequent nosebleeds, tendency to bruising or skin bleeding)?	<input type="checkbox"/>	<input type="checkbox"/>
Metabolic diseases (e.g. diabetes, thyroid disease, congenital metabolic disorder)?	<input type="checkbox"/>	<input type="checkbox"/>
Liver or kidney diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal/stomach problems (e.g. malformation of the gastrointestinal tract)?	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disease (e.g. epilepsy, paralysis, cerebral palsy, hydrocephalus)?	<input type="checkbox"/>	<input type="checkbox"/>
Muscle disorder (e.g. muscular dystrophy)?	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness (autism, ADHD, eating disorder, anxiety, panic attacks)?	<input type="checkbox"/>	<input type="checkbox"/>
Other diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Allergies and intolerances? If YES, which ones?	<input type="checkbox"/>	<input type="checkbox"/>
(If you have an allergy passport, please bring it with you on the day of anesthesia)		

Does your child take medication regularly? (If YES, which ones?)	<input type="checkbox"/>	<input type="checkbox"/>
Does your child (teenager) consume nicotine, alcohol, drugs? (If YES, what and how often?)	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have «wobbly teeth»?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke (parents, caregivers)?	<input type="checkbox"/>	<input type="checkbox"/>

**COMMENTS/QUESTIONS**

**Please let us know if your child's state of health should change during the time leading up to the operation (e.g. colds, fever, new medication, etc.).**

**Please send this form to at least 5 days before the planned procedure:**

AnästhesieZentrum.ch AG, Schaffhauserstrasse 124, 8057 Zürich, or via mail an: [anaesthesiezentrumb@hin.ch](mailto:anaesthesiezentrumb@hin.ch)

Place, Date

Signature

**Data protection declaration/General terms and conditions**

I hereby confirm with my signature that I consent to the processing of my child's data, access to the data by the doctor and the disclosure of the data to third parties in accordance with the patient information on the previous page. I also authorize the doctors of AnästhesieZentrum.ch AG to obtain medical data from other doctors or medical institutions.

I am aware of the possible risks of data exchange of particularly sensitive personal data (possible access by unauthorized third parties through insecure communication channels) as well as my rights and give my consent for mutual contact between my doctor and me as a patient through the contact information provided above. Patient information will only be passed on by the medical practice via secure communication channels. I agree that administrative matters such as rescheduling appointments may be handled via unencrypted e-mail communication.

The processing (collection, storage, use and retention) of patient data is based on the treatment contract and legal requirements to fulfill the purpose of treatment and the associated obligations. On the one hand, data is collected by the treating doctor as part of the treatment. On the other hand, we also receive data from other doctors and healthcare professionals with whom your child has been or is being treated, if you have given your consent. Only data relating to medical treatment will be processed in the medical history. The medical history includes the personal information provided on the patient form, such as personal details, contact details and insurance details, as well as, among other things, the consultation carried out as part of the treatment, health data collected such as anamnesis, diagnoses, therapy suggestions and findings.

You have the right to receive information about your child's personal data at any time until your child reaches the age of 18. You can view your medical history or request a copy. There may be a charge for providing a copy. You will be informed in advance of any costs, which depend on the time and effort involved in producing the copy.

By signing this document, I also accept the General Terms and Conditions of AnästhesieZentrum.ch AG, which can be accessed at any time via the following link: <https://www.anästhesiezentrumb.ch/terms-and-conditions>

Place, Date

Signature