ANÄSTHESIE ZENTRUM.CH
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Anästhesiezentrum.ch AG
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8057 Zürich
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Health questionnaire for adults

Dear patient

You are planning a treatment, examination or operation under anesthesia. In order to provide you with the best possible care and safety, we need precise information about your state of health. Thank you for completing this questionnaire carefully and returning it to us promptly.

PERSONAL DETAILS

Name:		First name:	
Date of birth:	Phone:	Height:	Weight:
General practitioner (name, place, telephone number):			

PLANNED TREATMENT / OPERATION:	Date of intervention:

PREVIOUS TREATMENTS / OPERATIONS	YES	NO
Have you already had an anesthesia? If so, what kind of anesthesia?	☐	☐
Were there any problems with previous anesthesia? If yes, please precise:	☐	☐
Have there been any problems with blood relatives in connection with anesthesia? If so, please precise:	☐	☐

YOUR CURRENT STATE OF HEALTH	YES	NO
Do you currently feel healthy and powerful?	☐	☐
Can you climb 2 stairs effortlessly (without shortness of breath)?	☐	☐
High blood pressure (also tick YES if well controlled with medication)?	☐	☐
Heart diseases (angina pectoris, heart attack, stents, cardiac insufficiency, heart valve disease, condition after heart surgery, condition after resuscitation)?	☐	☐
Cardiac arrhythmia (e.g. atrial fibrillation, pacemaker, defibrillator)?	☐	☐
Vascular diseases (venous disorders, condition following thrombosis/pulmonary embolism, arterial occlusive disease)?	☐	☐
Lung diseases (asthma, chronic bronchitis, home oxygen)?	☐	☐
Sleep apnea syndrome (OSAS)? If yes, do you have a therapy device? ☐ YES ☐ NO	☐	☐
Metabolic diseases (e.g. diabetes, thyroid disease, cholesterol)?	☐	☐
Diseases of the blood or blood clotting (e.g. leukemia, anemia, frequent nosebleeds, tendency to bruising or skin bleeding)?	☐	☐
Liver diseases?	☐	☐
Kidney diseases?	☐	☐
Stomach problems (e.g. burning stomach, reflux, gastric bypass, gastric banding)?	☐	☐
Muscle diseases (e.g. muscle weakness, muscular dystrophy)?	☐	☐
Mental illnesses (depression, anxiety, panic attacks, burnout, ADHS)?	☐	☐
Women of childbearing age: Could they currently be pregnant?	☐	☐
Other diseases?	☐	☐
Allergies and intolerances? If YES, which ones? **(If you have an allergy pass, please bring it with you on the day of anesthesia)**	☐	☐

Do you take blood-thinning medication? If YES, please precise?	☐	☐
Do you take any other medication regularly? If YES, please precise?	☐	☐
Do you consume alcohol? If YES, how often and how much?	☐	☐
Do you smoke? If YES, how many cigarettes a day? For how many years?	☐	☐
Do you consume drugs? If YES, which ones?	☐	☐
Do you wear dentures?	☐	☐

COMMENTS / QUESTIONS

Please let us know if your 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 by email to: anaesthesiezentrum@hin.ch

Place, date Signature

PRIVACY POLICY/GENERAL TERMS AND CONDITIONS

I hereby confirm with my signature that I consent to the processing of my 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 am aware of the possible risks of data exchange of particularly sensitive personal data (possible access by unauthorized third parties via insecure communication channels) as well as my rights and give my consent for mutual contact between my doctor and myself as a patient via 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 your data is based on the treatment contract and legal requirements to fulfil the purpose of treatment and the associated obligations. On the one hand, data is collected by the treating doctor as part of your treatment. On the other hand, we also receive data from other doctors and healthcare professionals with whom you have been or are being treated, if you have given your consent for this. Only data relating to your medical treatment will be processed in your 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 conducted as part of the treatment, health data collected such as medical history, diagnoses, therapy suggestions and findings.

You have the right to receive information about your personal data at any time. 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, 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.anaesthesiezentrum.ch/terms-and-conditions

Place, date Signature