Preoperative health questionnaire for adults - Anglais

Preoperative assessment clinic (UEP), CHVR
Internet: [http://www.hopitalvs.ch/uep](http://www.hopitalvs.ch/uep)

Please fill in this questionnaire before visiting the preoperative assessment clinic (UEP).
If necessary, your family doctor or the UEP nurse will help you with this questionnaire.

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<thead>
<tr>
<th>Last name:</th>
<th>First name:</th>
<th>Occupation:</th>
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<thead>
<tr>
<th>Height: cm</th>
<th>Weight: kg</th>
<th>Age: years</th>
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1. Are you currently under treatment for any medical condition?  
   No □ Yes □
   If so, which one(s)?
   ................................................................................................................................................................
   ................................................................................................................................................................

2. If this may concern you: are you pregnant?  
   No □ Yes □

3. Do you take any drugs or pills?  
   No □ Yes □
   If so, please state:

<table>
<thead>
<tr>
<th>Name of drug / pill</th>
<th>Dose</th>
<th>Morning</th>
<th>Noon</th>
<th>Night</th>
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4. Have you had any surgical interventions done before?  
   No □ Yes □
   If so, which interventions and when?

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<th>Intervention</th>
<th>Year</th>
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5. Do you know of any complications related to the anaesthetic? If so, which ones?  
No ☐ Yes ☐

To your knowledge, have any of your family members had any complication related to an anaesthetic?  
No ☐ Yes ☐

Do any of your family members suffer from muscular disorders?  
No ☐ Yes ☐

**Have you ever had any of the following health problems:**

6. Muscular disorders or muscle weakness?  
No ☐ Yes ☐

7. Heart problems (heart attack, angina, breathing problems when walking up a flight of stairs, palpitations of the heart)?  
No ☐ Yes ☐

8. Problems with your circulation and blood vessels (high blood pressure, cramps, thrombosis, embolism, bleeding, varicose veins)?  
No ☐ Yes ☐

9. Lung problems or breathing problems (tuberculosis, pneumonia, asthma, bronchitis)?  
No ☐ Yes ☐

10. Problems with your liver or gallbladder (jaundice)?  
No ☐ Yes ☐

11. Kidney problems (pyelonephritis, kidney stones, infections)?  
No ☐ Yes ☐

12. Metabolic diseases (high blood sugar, gout)?  
No ☐ Yes ☐

13. Hormonal problems (thyroid gland, goiter)?  
No ☐ Yes ☐

14. Problems with your eyes (glaucoma)?  
No ☐ Yes ☐

15. Neurologic conditions (epilepsy, paralysis)?  
No ☐ Yes ☐

16. Mood disorders (depression)?  
No ☐ Yes ☐

17. Skeletal or bone problems (herniated disks, joint problems, arthritis)?  
No ☐ Yes ☐

18. Blood or coagulation disorders (hematoma, bleeding)?  
No ☐ Yes ☐

19. Allergies (hay fever, food allergies, drug allergies)?

If so, please state: .........................................................................................

No ☐ Yes ☐

20. Are you aware of any other medical condition not mentioned so far?

If so, which one(s)?

No ☐ Yes ☐

21. Do you have any false teeth?  
No ☐ Yes ☐

22. Are you a smoker?

If so, how many cigarettes per day: ................................., since ..............year

No ☐ Yes ☐

23. Do you regularly take alcohol?

If so, how much: ............................................

No ☐ Yes ☐

Would you like to add any information?

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.................................................................

.................................................................

Date: ................................................................. Signature: .................................................................