CHVR - Preoperative health questionnaire for adults - Anglais

Réf. : FO-3584
Version : 8
Processus : * 3.2.10.01.05.02 Consentements et questionnaires de santé

Hôpital du Valais
Spital Wallis

Preoperative assessment clinic (UEP), CHVR

Internet : http://www.hopitalvs.ch/uep

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Please fill in this questionnaire before visiting the preoperative assessment clinic (UEP).

Last name : ..... First name : ..... Occupation : .....

Height : .....cm Weight : ..... kg Age : ..... years

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:

Name of drug / pill	Dose	Morning	Noon	Night

4. Have you had any surgical interventions done before? No ☐ Yes ☐
   if so, which interventions and when ?

Intervention	Year

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 ☐

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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. Sketelal 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) ? No ☐ Yes ☐

    If so, please state : .....
20. Are you aware of any other medical condition not mentioned so far ? No ☐ Yes ☐
    If so, which one(s)?

    .....
21. Do you have any false teeth? No ☐ Yes ☐
22. Are you a smoker? No ☐ Yes ☐
    If so, how many cigarettes per day :....., since .....year
23. Do you regularly take alcohol? No ☐ Yes ☐
    If so, how much: .....
24. Have you ever developed anticipated guidelines or named a therapeutic representative? No ☐ Yes ☐

Would you like to add any information?

.....

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.....

.....

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