

Réf. : FO-3584

Version : 8

Processus : * 3.2.10.01.05.02 Consentements et questionnaires de santé

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

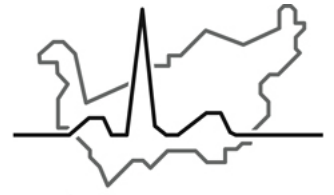
4. Have you had any surgical interventions done before? No Yes
if so, which interventions and when ?

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

CHVR - Preoperative health questionnaire for adults - Anglais



Hôpital du Valais
Spital Wallis

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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 :....., sinceyear
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 :