

Practice stamp

**Details of the operation (to be completed by the surgeon)**

|                     |                       |                   |
|---------------------|-----------------------|-------------------|
| Operation:<br>..... | Op duration:<br>..... | Date:<br>.....    |
| Details:<br>.....   |                       | Surgeon:<br>..... |

**Payment details (to be completed by the surgeon / clinic / practice)**

<sup>1</sup> Swiss Accident Insurance Institute  
<sup>2</sup> Disability insurance  
<sup>3</sup> Military insurance

|  |  |  |
|--|--|--|
| Health insurance fund <input type="checkbox"/> | Flat rate <input type="checkbox"/>   | IV: Please enclose ruling or ruling number and IV number |
| Self-pay patient <input type="checkbox"/>      | SUVA <sup>1</sup> /IV <sup>2</sup> /MV <sup>3</sup> <input type="checkbox"/> | SUVA: Please state date of accident                      |

**Personal details (to be completed by the patient)**

|   |                          |  |  |
|---|--------------------------|--|--|
| Last name:<br>.....   | First name:<br>.....     | Sex<br><input type="checkbox"/> f <input type="checkbox"/> m | D.O.B.:<br>.....   |
| Street:<br>.....  | Post code/City:<br>..... | Height (cm):<br>.....  | Weight (kg):<br>.....  |
| Home tel.:<br>.....   | Work tel.:<br>.....      | Profession:<br>.....   |  |
| Last name/first name of parents (if the patient is a child):<br>.....     |                          |  | Sex<br><input type="checkbox"/> f <input type="checkbox"/> m |
| Name, address of legal representative / guardian / nursing home:<br>..... |                          |  |  |
| Tel. no. ....   |                          |  |  |
| Name, address of family doctor/GP:<br>.....                               |                          |  |  |
| Tel. no. ....   |                          |  |  |

**Health details (to be completed by the patient before the pre-operation discussion)**

|   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Have you received medical treatment recently?<br>What for? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you currently have a cold?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you experienced diarrhoea and/or vomiting in the last four weeks?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any other infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you taken any coagulation-inhibiting medication in recent weeks? E.g. Aspirin, Marcumar<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take any other medication? E.g. blood pressure/heart medication, painkillers, antipsychotic drugs,<br>anti-diabetic drugs, contraceptive pill<br>or: .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had an operation before? Please state type and year of operation:<br>.....<br>.....<br>.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever suffered nausea and vomiting after an operation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you, or do you still, suffer from complaints (e.g. positioning damage) after a previous general anaesthetic, regional<br>anaesthetic or local numbing?<br>What sort?<br>..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any blood relations experienced irregularities in connection with anaesthesia?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been infused with blood or blood components (transfusion)?<br>If so, when? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Were there any complications? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| For female patients: Is there a possibility you may be pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any piercings?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you climb 2 flights of stairs without any problem?<br>If not, why?<br>.....<br>.....  | <input type="checkbox"/> | <input type="checkbox"/> |

|   |                          |                          |
|---|--------------------------|--------------------------|
| Patient: First name/last name/year of birth<br>.....  | Surgeon<br>.....         | Op date<br>.....         |
| <b><u>Do you have, or have you ever had, the following illnesses or symptoms thereof?</u></b>   |                          |                          |
|   | <b>Yes</b>               | <b>No</b>                |
| Heart/Circulation: Dysrhythmia, heart failure, angina pectoris, infarction, myocarditis, high or low blood pressure<br>or: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Vascular: Varicose veins, thromboses, blood circulation problems, stroke<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Airways/Lungs: Chronic bronchitis, asthma, pneumonia, TB, pulmonary emphysema, sleep apnoea, paralysis of the vocal chords, diaphragmatic paralysis<br>or: .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver: Jaundice, hardening of the liver, fatty liver, gallstones<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Renal: Kidney stones, nephritis, need for dialysis, high renal values<br>or: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Oesophagus, stomach, intestine: Ulcer, stenosis, dyspepsia, heartburn, reflux disease<br>or: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Metabolism: Diabetes, gout<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid: Overactive or underactive thyroid, goitre<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Skeletal system: Arthropathy, Back/spinal disc complaints, shoulder-arm-syndrome<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Nerves, mind: Seizures (epilepsy), paralysis, depression, frequent headaches<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes: Glaucoma, cataract, contact lenses<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood: Blood-clotting disorder (including in blood relatives), frequent nosebleeds, bruises even after no injury or just light contact, post-operative haemorrhage<br>or: ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscles: Myasthenia, myopathy (including in blood relatives)<br>or: .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies/Hypersensitivity: Hay fever, foods, fructose, medications, iodine, plaster, latex (balloons, erasers, rubber gloves)<br>or: .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Other diseases or disabilities?<br>.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic pain?<br>.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Loose teeth, cavities?<br>.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing difficulties?<br>.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing aid?<br>.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke? If so, what and how much per day?<br>.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink alcohol? If so, what and how much per day?<br>.....<br>How often?<br>.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take drugs? If so, what and how much per day?<br>.....<br>How often?<br>.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you regularly take sleeping pills or sedatives? Which ones?<br>.....   | <input type="checkbox"/> | <input type="checkbox"/> |

**Please enclose a detailed medical report (e.g. from your GP) if the following complaints apply**

- Have had an infarction or regularly experience angina pectoris
- Have a heart condition or heart valve disease
- Have had a heart or lung operation (including pacemaker and/or intracardiac catheter)
- Have asthma requiring treatment or a chronic cough with sputum
- Experience lengthy bleeding after injuries, regularly large haematomas, frequent bleeding when brushing teeth
- Have epilepsy, or mental or intellectual disorder or limitation
- Have amyotrophia, spasticity or other muscular disorders

Comments: .....

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I confirm I have completed this medical history form truthfully, in full and to the best of my knowledge.

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

⇒ Fax 052 320 01 21