

Practice stamp

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

Operation:	Op duration:	Date:
Details:	Surgeon:	

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

¹ Swiss Accident Insurance Institute
² Disability insurance
³ 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 ¹ /IV ² /MV ³ <input type="checkbox"/>	SUVA: Please state date of accident

Personal details (to be completed by the patient)

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

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

	Yes	No
Have you received medical treatment recently? 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 or:	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any other medication? E.g. blood pressure/heart medication, painkillers, antipsychotic drugs, anti-diabetic drugs, contraceptive pill or:	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an operation before? Please state type and year of operation:	<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 anaesthetic or local numbing? What sort?	<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)? 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? If not, why?	<input type="checkbox"/>	<input type="checkbox"/>

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

.....

.....

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

Date: Signature:

⇒ Fax 041 379 70 31