anaPRax ambulante anästhesie

MEDICAL HISTORY FORM

PERSONAL INFORMATION

Surname	First name	Gender (anatomical)	
		☐ m	☐ f
Street and number	Postcode and town / city	Date of birth	Email address
Phone 1	Phone 2	Height [cm]	Weight [kg]	Name of general practitioner practice

OPERATION INFORMATION

Operation date	Practice / clinic	Surgeon

HEALTH INFORMATION

			Comments
> Do you feel healthy? If not, why?	☐ yes	☐ no	
> Have you been under medical treatment in the last few months? For what?	☐ yes	☐ no	
> Have you had a cold in the past 14 days?	☐ yes	☐ no	
> Do you have any allergies to medicines, iodine, grasses, food, contrast media or other things?	☐ yes	☐ no	
> Have you taken any anticoagulant medication in the last few weeks? (e.g., Aspirin, Marcoumar, Plavix or others)	☐ yes	☐ no	
> Are you taking any other medication? (e.g., blood pressure / heart medication, diabetes mellitus, painkillers, psychotropic drugs, birth control pills, or others)	☐ yes	☐ no	
> Have you ever undergone an operation? Please indicate the operation and the year:	☐ yes	☐ no	
> Did you suffer from nausea and / or vomiting after the operation?	☐ yes	☐ no	
> Were there any special conditions involving blood relatives in connection with anaesthesia? If so, which ones?	☐ yes	☐ no	
> Have you ever been administered blood or blood components?	☐ yes	☐ no	
> For female patients: Is there a possibility of pregnancy?	☐ yes	☐ no	
> Do you have any piercings? Where?	☐ yes	☐ no	
> Can you easily climb two flights of stairs?	☐ yes	☐ no	

> Do you have or have ever suffered from (please underline accordingly):

> Cardiovascular system: arrhythmias, heart defects, angina pectoris, too high / low blood pressure, or others?	☐ yes	☐ no
> Vessels: thromboses, embolisms, varicose veins, strokes, or others?	☐ yes	☐ no

anaPRaX AG | St. Niklausstrasse 5 | Müllerhof | CH-4500 Solothurn | fon +41 (0)62 296 32 38 | mail anaPRaX@hin.ch | web www.anaPRaX.ch

>	Respiratory system: chronic bronchitis, asthma, pneumonia, TBC, sleep apnea syndrome, or others?	□ yes	□ no
>	Liver: jaundice, fatty liver, gallstones, or others?	□ yes	□ no
>	Infectious disease: HIV, hepatitis, etc.?	□ yes	□ no
>	Kidney: elevated kidney values, kidney stones, kidney inflammation or others?	□ yes	□ no
>	Esophagus, stomach, intestines: constriction, ulcer, reflux disease, heartburn, or others?	□ yes	□ no
>	Metabolism: diabetes (diabetes mellitus type 1 or 2), gout, or others?	□ yes	□ no
>	Thyroid: under or overactive, goitre or other?	□ yes	□ no
>	Skeletal system: joint diseases, back and intervertebral disc problems, or others?	□ yes	□ no
>	Nerves, mind: seizures, depression, paralysis, or others?	□ yes	□ no
>	Eyes: glasses, contact lenses, glaucoma, cataracts or others?	□ yes	□ no
>	Blood: coagulation disorders, frequent nosebleeds, easy bruised, or others?	□ yes	□ no
>	Muscles: muscle weakness, muscle diseases (also in blood relatives), or others?	□ yes	□ no
>	Other illnesses or disabilities?	□ yes	□ no
>	Chronic pain?	□ yes	□ no
>	Loose teeth, tooth decay?	□ yes	□ no
>	Are you a smoker? If so, what and how much per day?	□ yes	□ no
>	Do you drink alcohol? If so, what and how much per day / week?	□ yes	□ no
>	Do you use drugs? If yes, then which ones and how often?	□ yes	□ no
>	Do you take sleeping pills and / or sedatives on a regular basis? If so, which ones?	□ yes	□ no

SPECIAL, OTHERS

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CONFIRMATION AND DECLARATION OF CONSENT

I confirm that I have read and understood the document "Information sheet on outpatient anaesthesia" and will follow the recommendations and prescriptions contained therein. With my signature I also confirm the accuracy of the information.

Date

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Signature of the patient (or legal representative)

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→ Please complete and sign the medical history form and send it to anaPRaX by post or email in good time.

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