

Barcodeaufkleber

Preoperative Medical History Form for Adults

Dear Patient,

You are to undergo surgery. Many possible complications can be avoided if potential sources of danger and risk factors (i.e. diabetes, blood coagulation disorders) are communicated on time. In answering questions about your medical history you can help us find any possible health problems, evaluate the risk of an operation or anesthesia and so be able to prepare for the operation.

Physical condition, habits

Age _____

Height _____cm

Weight _____kg

What do you or did you do professionally?

Do you engage in any sport / fitness regularly? ☐ no ☐ yesDo you smoke? ☐ no ☐ yes

If yes, how many cigarettes per day? _____

Do you drink alcohol? ☐ no ☐ yes

If yes, which alcoholic beverages? _____

How much per day? _____

Do you take any medication regularly (for example aspirin, coumarin derivatives, pain medication, sleeping pills, heart medication or cardiovascular agents, laxatives, tranquilizers)? ☐ no ☐ yes

If yes, which? _____ How many per day? _____

Do you wear a hearing aid? ☐ no ☐ yesDo you wear contact lenses? ☐ no ☐ yesDo you have a pacemaker? ☐ no ☐ yesDo you have dental prosthesis (pivot tooth, jacket crown, bridgework, removable prosthesis) or braces? ☐ no ☐ yesDo you have loose teeth? ☐ no ☐ yesDental status (is filled in by the **doctor**)?

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| O loose | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| X missing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you suffer from dental diseases (caries, parodontal disease)? ☐ no ☐ yesHave you been under medical care recently? ☐ no ☐ yes

If yes, for what reason? _____

Previous operationsHave you been operated on before? ☐ no ☐ yesDid you tolerate the anesthesia well? ☐ no ☐ yes

If not, what particularities did you suffer from? _____

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Did any blood-relative ever experience complications related to anesthesia?

☐ no ☐ yes

Have you ever had...

a) A blood transfusion (foreign or own blood)?

☐ no ☐ yes

b) Blood products (packed cells, FFP, clotting factors)?

☐ no ☐ yes

c) if yes, did complications arise?

☐ no ☐ yes

Previous Injuries

Have you suffered injury in the past?

☐ no ☐ yes

If yes, please check appropriate box:

☐ Abdominal injuries

☐ Chest injuries

☐ Head injuries

☐ Broken bones

☐ Burns

☐ Chemical burns

Do you or did you suffer from the following diseases?

Allergies / allergic reactions?

☐ no ☐ yes

If yes, towards what? Please check appropriate box:

☐ Food

☐ Anesthetics or narcotics

☐ Yeast

☐ Medication, which?

☐ Fructose

☐ Fruit

☐ Synthetic materials

☐ Iodine

☐ House dust

☐ Vaccines

☐ Rubber

☐ Plaster

☐ Metals

☐ Wound dressings

☐ Pollen

☐ X-ray contrasting agent

Diseases of the immune system, low resistance, AIDS?

☐ no ☐ yes

Muscular disease or weakness, predisposition to malignant hyperthermia?

☐ no ☐ yes

Disease of the nervous system? If so, which:

☐ no ☐ yes

- Epilepsy?

☐ no ☐ yes

- Paralysis?

☐ no ☐ yes

- Inflammation of the nerves?

☐ no ☐ yes

Meningitis?

☐ no ☐ yes

Mood disorders (e.g. depression)

Phobias, psychiatric disorders?

☐ no ☐ yes

Disease of lungs or respiratory tract?

☐ no ☐ yes

If so, which:

- Asthma?

☐ no ☐ yes

- Sleep apnea?

☐ no ☐ yes

- Chronic bronchitis?

☐ no ☐ yes

- Tuberculosis?

☐ no ☐ yes

- Pulmonary emphysema?

☐ no ☐ yes

- Pulmonary disease due to dust inhalation?

☐ no ☐ yes

- Pneumonia?

☐ no ☐ yes

Eye Ailments (e.g. glaucoma)?

☐ no ☐ yes

Heart disease, diseases of the circulation? If so, which?

☐ no ☐ yes

- Myocardial infarction, heart-rhythm irregularities, valvular defect?

☐ no ☐ yes

- Chest pain without exertion?

☐ no ☐ yes

- Chest pain upon exertion?

☐ no ☐ yes

- Shortness of breath upon exertion?

☐ no ☐ yes

- Shortness of breath when resting?

☐ no ☐ yes

- Too high or too low blood pressure? ☐ no ☐ yes

- Impaired perfusion (in the legs, arms or brain)? ☐ no ☐ yes

Diseases of the blood and blood vessels? If so, which? ☐ no ☐ yes

- Leukemia? ☐ no ☐ yes

- Phlebitis? ☐ no ☐ yes

- Coagulation defects? ☐ no ☐ yes

- Thrombosis (Blood clots in the veins)? ☐ no ☐ yes

- Embolism (arterial occlusion due to blood clot)? ☐ no ☐ yes

Diseases of the digestive system? If so, which: ☐ no ☐ yes

- Pancreatitis (inflammation of the pancreas) ☐ no ☐ yes

- Gallstones? ☐ no ☐ yes

- Diseases of the liver (e.g. jaundice, hepatitis, cirrhosis, fatty degeneration of liver)? ☐ no ☐ yes

- Diseases of the stomach (e.g. gastritis, ulcers) ☐ no ☐ yes

- Diverticular disease? ☐ no ☐ yes

- Chronic bowel disorders (e.g. Crohn's disease, ulcerative colitis)? ☐ no ☐ yes

- Bowel obstruction? ☐ no ☐ yes

- Haemorrhoids? ☐ no ☐ yes

Diseases of the kidneys and urinary tract? If so, which: ☐ no ☐ yes

- Kidney stones? ☐ no ☐ yes

- Nephritis? ☐ no ☐ yes

- Pyelonephritis? ☐ no ☐ yes

- Bladder stones? ☐ no ☐ yes

- Cystitis? ☐ no ☐ yes

Diseases of the skeletal system? If so, which: ☐ no ☐ yes

- Spinal ailments (e.g. slipped disc)? ☐ no ☐ yes

- Diseases of the joints (e.g. arthritis, arthrosis, gout)? ☐ no ☐ yes

- Diseases of the bones (e.g. osteoporosis, repeatedly broken bones, osteomyelitis)? ☐ no ☐ yes

Other diseases:

Hernias of the abdominal wall (e.g. inguinal hernia, umbilical hernia)? ☐ no ☐ yes

Dermatological diseases (e.g. neurodermatitis, rashes, pus formation)? ☐ no ☐ yes

Thyroid diseases (overactive, underactive)? ☐ no ☐ yes

Metabolic diseases (e.g. diabetes)? ☐ no ☐ yes

Swelling of the lymph nodes? ☐ no ☐ yes

Tumors (cancer)? ☐ no ☐ yes

Wound infections, inflammations? ☐ no ☐ yes

Intoxication? ☐ no ☐ yes

Men: Prostate enlargement? ☐ no ☐ yes

Women prior to menopause: Could you presently be pregnant? ☐ no ☐ yes

Other diseases not mentioned above? ☐ no ☐ yes

If so, which?

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Do you suffer from the following ailments?

- Lack of appetite? ☐ no ☐ yes
- Problems swallowing? ☐ no ☐ yes
- Heartburn? ☐ no ☐ yes
- Stomach ache? ☐ no ☐ yes
- Flatulence, digestive problems? ☐ no ☐ yes
- Nausea, vomiting? ☐ no ☐ yes
- Diarrhoea? ☐ no ☐ yes
- Constipation? ☐ no ☐ yes
- If yes, were enemas or laxatives necessary? ☐ no ☐ yes
- Bleeding of the bowels? ☐ no ☐ yes
- Biliary colic? ☐ no ☐ yes
- Renal colic? ☐ no ☐ yes
- Frequent urge to urinate? ☐ no ☐ yes
- Sensation of burning when urinating? ☐ no ☐ yes
- Coughing with sputum production? ☐ no ☐ yes
- Frequent nosebleeds? ☐ no ☐ yes
- Angina pectoris? ☐ no ☐ yes
- Frequent headaches? ☐ no ☐ yes
- Back aches? ☐ no ☐ yes
- Leg aches? ☐ no ☐ yes

If yes:

☐ without exertion☐ with exertionCapability to walk metres.

Do you have a tendency towards haematomas and bruises without known reason?

☐ no ☐ yes

Frequent itching of the skin?

☐ no ☐ yes

Overgrowth of scar tissue (keloids) or slow healing?

☐ no ☐ yes

Awareness problems, memory lapses?

☐ no ☐ yes

Dizziness, unconsciousness?

☐ no ☐ yes

Problems with sleeping?

☐ no ☐ yes

Who is your primary care physician?

Name: _____

Address: _____

Telephone number: _____

Patient's Statement☐ I read this questionnaire completely and answered all questions to my best knowledge.☐ I would like more information about:

Date and signature

Date: _____

Patient's signature/custodian

Surgeon's signature