Information about the operation (to be completed by the surgeon/practice)		
Operation	Procedure duration min	Procedure date
Operating surgeon		

Information on the customer (to be completed by the surgeon/practice)		
☐ Insurance provider	☐ SUVA / LI* / MI*	LI: Please specify LI no. and mandate / mandate no.
☐Self-paid	☐Flat fee	SUVA: Please state the date of the accident

Information about the patient (to be completed by the patient)			
Surname ……	First name ……	Gender ☐ f ☐m	Date of birth ……
Address ……	Location / postal code ……		
Tel G ……	Tel P ……	Mobile ……	
Email ……		Pension insurance no. ……	
If the patient is a minor, name and first name of the parents ……			
Name and address of the legal representative (guardian) …… Telephone no. ……			
Name and address of the family doctor ……			
Do you understand German? ☐ yes ☐ no → please bring a German-speaking companion with you			
Do you have a patient decree? ☐ yes ☐ no → please bring this with you on the day of the operation			

Information on the state of health (to be filled in by the patient before speaking with the anaesthetist, together with a doctor if necessary)	
Size in cm ……	Weight in kg ……
Have you received medical treatment in recent weeks? If so, for what reason? ……	☐ yes ☐no
Have you ever had an operation? If so, for what reason? ……	☐ yes ☐no
Have you experienced any exceptional occurrences during general or regional anaesthesia? If yes, please give details. ……	☐ yes ☐no
Have you suffered from nausea or vomiting after anaesthesia?	☐ yes ☐no
Have there been any exceptional occurrences when relatives were anaesthetised? If yes, please give details. ……	☐ yes ☐no
Do you have a cold? ……	☐ yes ☐no
Do you have a fever? ……	☐ yes ☐no

Do you have any other infection(s)? If yes, please give details.	☐ yes ☐no
Have you ever had a blood transfusion?	☐ yes ☐no
Could you be pregnant?	☐ yes ☐no

Information on the state of health, organ-specific (to be filled in by the patient before speaking with the anaesthetist, together with a doctor if necessary)	
Can you climb 2 floors of stairs without stopping	☐ yes ☐no
Cardiovascular disease: High blood pressure? Coronary arteries? Heart valves? Arrhythmias? Other:	☐ yes ☐no ☐ yes ☐no ☐ yes ☐no ☐ yes ☐no
Blood vessel disease: Varicose veins? Thrombosis? Stroke?	☐ yes ☐no ☐ yes ☐no
Lungs & airways: Asthma or chronic bronchitis? Sleep apnea? If so → do you have a CPAP device? ☐ yes ☐no	☐ yes ☐no ☐ yes ☐no
Liver: Hepatitis Other:	☐ yes ☐no
Gastrointestinal or oesophagus: Reflux / acid regurgitation?	☐ yes ☐no
Kidneys: Elevated kidney values? ..... Other:	☐ yes ☐no
Metabolism: Diabetes Thyroid	☐ yes ☐no ☐ yes ☐no
Muscle diseases:	☐ yes ☐no
Skeletal system: Joint disease or problems with the cervical vertebrae	☐ yes ☐no
Nervous system: Seizures (epilepsy) Migraines or depression	☐ yes ☐no ☐ yes ☐no
Allergies: ☐ yes → which ..... please bring your allergy pass with you **Intolerances:** ☐ yes → which	
Do you wear dentures or have loose teeth?	☐ yes ☐no
Do you consume alcohol or nicotine regularly?	☐ yes ☐no
Do you use drugs?	☐ yes ☐no
Own remarks	

Information on medication intake (to be filled in by the patient before speaking with the anaesthetist, together with a doctor if necessary)	
Do you take anticoagulant medication? If yes, please give details	☐ yes ☐no
Do you take other medications? If yes, please give details	☐ yes ☐no

Please also take note of our patient information leaflets.

I confirm that I have completed this form for recording my medical history to the best of my knowledge, completely and truthfully, and that I have read and understood the information leaflets.

IPe, 25.1.2021, Version 5

Date: ……. Signature: ……..