Surname, First name	Date of birth

MERIAN ISELIN

Klinik für Orthopädie und Chirurgie

Pre-anaesthesia consultation

Please complete this patient information and medical history questionnaire and bring it with you to the pre-anaesthesia consultation.

Dear Patient

It is important for us to ensure that your anaesthesia can be carried out as carefully and as safely as possible.
To do this, we rely on information about your state of health which you will provide through your answers in this questionnaire.

We would therefore ask you to read through the questionnaire carefully and answer all the questions below and on the back of this questionnaire.

If you need any help filling in the questionnaire or if you are unsure about any individual questions, please ask your specialist during the pre-anaesthesia consultation.

The completed questionnaire is used as preparation for the personal interview with your doctor in the pre-anaesthesia consultation, when you will have an opportunity to discuss everything you would like to know with regard to your anaesthesia.
If you wish, your anaesthesiologist may also explain to you any rare risks associated with the anaesthesia.

Please make a note below of everything you would like to ask or discuss with your anaesthesiologist:

The anaesthesia procedure was explained to me by Dr.

Planned anaesthesia:

Basel, date Patient

Questions about your medical history

	Question		
1.	Do you regularly take any medication? If so, which medication?	no	yes
2.	Have you recently been receiving medical treatment? If so, what for?	no	yes
3.	What is your occupation?		
4.	Have you ever had surgery before? If so, what and when?	no	yes
	Did you tolerate the anaesthesia well? If not, why not?	no	yes
5.	Do you suffer from a heart disease? (e.g. angina, myocardial infarction, etc.)	no	yes
6.	Do you suffer from any disease of the circulation or blood vessels? (high / low blood pressure, thromboses, varicose veins, etc.)	no	yes
7.	Do you suffer from respiratory disease? (chronic bronchitis, asthma, etc.)	no	yes
8.	Do you suffer from liver disease? (jaundice, cirrhosis)	no	yes
9.	Do you suffer from kidney disease? (kidney stones, inflammation)	no	yes
10.	Do you have a metabolic disease? (diabetes)	no	yes
11.	Do you suffer from stomach problems? (stomach ulcer, heartburn, reflux)	no	yes
12.	Do you suffer from any thyroid condition? (goitre, over-active / under-active thyroid)	no	yes
13.	Do you have any disease of the skeletal system? (spinal damage, etc.)	no	yes
14.	Do you have any blood disease or increased tendency to bleed? (disorder of blood clotting, nosebleeds, bruising)	no	yes
15.	Do you smoke regularly? If so, how many per day?	no	yes
16.	Do you suffer from allergies? (hay fever, medicines, foods, etc.) If so, which allergies?	no	yes
17.	Do you drink alcohol with meals? If so, what and how much per day / week?	no	yes
18	Do you wear eye contacts?	no	yes
19.	Do you have any dental problems? (dentures, loose teeth)	no	yes
20.	Do you suffer from muscle weakness?		no
	Do any of your blood relatives suffer from any muscle disorders?	no	yes
21.	Do you suffer from any disease of the nervous system? (epilepsy, migraine, etc.)	no	yes
22.	Have you ever received blood transfusions?	no	yes
23.	Do you do any sport regularly? If so, what sport?	no	yes
24.	Is it possible you might be pregnant at the moment?	no	yes
25.	Are there any other issues in your medical history, such as diseases and accidents not listed above?	no	yes
26.	Have you already had a preliminary examination with your GP? (e.g. blood sample taken, ECG)	no	yes

27. Age: Height in cm: Weight in kg: