



Personal questionnaire

First name

Surname

Sex

Date of birth

Street

Postcode/City

Weight (kg)/Height (cm)

Planned surgery date

Phone No.

E-Mail

Your attending surgeon

Did you undergo any surgery or medical intervention in the past? Please, briefly describe the kind of surgery and the year it happened.

Intervention

Year

<input type="text"/>
<input type="text"/>
<input type="text"/>

<input type="text"/>
<input type="text"/>
<input type="text"/>

Do you regularly take medication (including blood thinners and cardiovascular medications)? Please note the name of the medication and the taking frequency.

<input type="text"/>
<input type="text"/>
<input type="text"/>

Do you or did you suffer in the past from any of the diseases listed below? Please, check the applicable ones and mention, since when you suffer from it or when you last experienced it.

Disease	If yes, when	Disease	If yes, when
<input type="checkbox"/> allergies	<input type="text"/>	<input type="checkbox"/> lung disease	<input type="text"/>
<input type="checkbox"/> heart disease	<input type="text"/>	<input type="checkbox"/> liver disease	<input type="text"/>
<input type="checkbox"/> cardiovascular disease	<input type="text"/>	<input type="checkbox"/> kidney disease	<input type="text"/>
<input type="checkbox"/> blood pressure disorder	<input type="text"/>	<input type="checkbox"/> metabolic disease	<input type="text"/>
<input type="checkbox"/> vascular disease	<input type="text"/>	<input type="checkbox"/> diabetes	<input type="text"/>
<input type="checkbox"/> anaemia	<input type="text"/>	<input type="checkbox"/> gastrointestinal disease	<input type="text"/>
<input type="checkbox"/> bleeding tendency	<input type="text"/>		
<input type="checkbox"/> neurological disease	<input type="text"/>	<input type="checkbox"/> others: <input type="text"/>	<input type="text"/>



Continue on the backside



We need further information from you.

Did you undergo any medical treatment during the last three months?
If so, why?

Do you consume nicotine, alcohol or drugs?
If so, what, how often and how much?

Did you - or blood relatives – ever have any anesthesia complications?
If yes, which ones?

Other important complications?
If yes, which ones?

Please send us this form as soon as possible, but **not later than 7 days before the planned operation** by post, by fax or by e-mail (all details in the footer).

If you have questions about the upcoming anesthesia, do not hesitate to contact us in time.

IMPORTANT: Tell us immediately about changes in your state of health while waiting for the surgery day! (Eg: colds, new medication, worsening of the general condition)

I have understood and truthfully completed this questionnaire

City, date:

Signature:

We thank you for the cooperation and look forward to welcoming you on the surgery day.