PRE-HOSPITALIZATION FORM

This form is to be filled in and sent by fax or delivered upon pre-hospitalization visit

Dear patient,

You have been listed for a surgical intervention to be performed at one of our clinics. Please fill in this form in all its parts and bring it with you when you attend the pre-hospitalization visit at the clinic where you will undergo surgery. Thank you!

PLEASE FILL IN BLOCK LETTERS

PATIENT DATA

Surname **Name**
Date of birth Height cm Weight kg

FAMILY DOCTOR **Tel. no.**

Did you undergo specialist or medical examinations or receive medical treatment in the last 6 months?
If yes, when, where and why ☐ yes ☐ no

Have you already been hospitalized for any health problems or for surgical interventions in the past?
If yes, when, where and why? **?** ☐ yes ☐ no

Did complications arise during surgical intervention or anesthesia performed on you or on a member of your family?
If yes, what kind of complications? ☐ yes ☐ no

How many steps are you able to climb without pause?
☐ more than 20 steps ☐ more than 10 steps ☐ less than 10 steps

Do you suffer from allergies? ☐ yes ☐ no
If yes, to what? (for example: medicines, plasters, iodine, latex, food, metals)

Do you take medicines regularly? ☐ yes ☐ no
If yes, which ones? What's their commercial name and when to you take them?

Do you take antiplatelet agents? ☐ yes ☐ no
If yes, which ones? What's their commercial name and when to you take them?

Do you take anticoagulants? ☐ yes ☐ no
If yes, which ones? What's their commercial name and when to you take them?

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Do you suffer or have you suffered from one of the following health problems?

High blood pressure	☐ no ☐ yes
Chest pain (angina pectoris)	☐ no ☐ yes, with what frequency?
Other heart diseases (e.g. valve fault, irregular pulse, need a pace-maker)	☐ no ☐ yes, which?
Difficulty in breathing (e.g. when lying down)	☐ no ☐ yes, when?
Chronic bronchitis	☐ no ☐ yes, have there been changes? ...
Asthma	☐ no ☐ yes, when?
Other respiratory problems (e.g. sleep apnea)	☐ no ☐ yes, which?
Heartburn or reflux	☐ no ☐ yes, when?
Diabetes	☐ no ☐ yes
Epilepsy	☐ no ☐ yes, with what frequency?
Stroke	☐ no ☐ yes
Dizziness	☐ no ☐ yes, when?
Panic attacks	☐ no ☐ yes, when?
Restless legs syndrome	☐ no ☐ yes, when?
Pain/problems with the back	☐ no ☐ yes, what?
Thrombosis or embolism	☐ no ☐ yes, what?
Frequent bleeding from the nose/gums, or hematomas	☐ no ☐ yes, when?
Anemia	☐ no ☐ yes
Kidney problems	☐ no ☐ yes, which?
Liver problems	☐ no ☐ yes, which?
Do you smoke?	☐ no ☐ yes, how much/many daily?
Do you drink alcohol?	☐ no ☐ yes, how much/many daily?
Did you considerably gain or lose weight in the last 4 months?	☐ no ☐ yes, how much? Was it weight loss or increase?
Are you pregnant?	☐ no ☐ yes
Do you suffer from any other health problem that was not been mentioned above? If yes, which ones?	☐ no ☐ yes

…… ……

Date

Signature of patient

……

Signature of parent or legal representative

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