MARTINI-KLINIK

To prepare for your surgery

Personal data and anamnesis

Universitätsklinikum Hamburg-Eppendorf UKE HAMBURG

Anamnesis Questionnaire: Your medically relevant information for the surgical preparation

Dear patient,

You will shortly be treated at our clinic. This questionnaire is for you to enter your individual medical history. This makes it easier for us to get an overall idea of your condition and to also record non-urological diseases accurately.

Please complete this questionnaire carefully during the time leading up to treatment. There will, of course, be a medical- and nursing-related admission and briefing discussion, as well as a thorough examination. Filling out this questionnaire will give you the opportunity to think over any important matters without being pressed for time.

Personal data

Name

Date of birth

Body height / Body weight

Profession

Address

Phone number / mobile

E-Mail

Relative / contact person
during your stay at the Martini-Klinik

Mobile of relative / contact person
during your stay at the Martini-Klinik

General information

_____
Your urologist

_____
GP / home care

_____
Other attending physicians

What medical treatment do you request?

Open surgery	☐ Yes	☐ No
Da Vinci Surgery	☐ Yes	☐ No
External radiotherapy	☐ Yes	☐ No
Internal radiotherapy (Brachy)	☐ Yes	☐ No
Medication therapy	☐ Yes	☐ No
I have not yet made a decision for a particular therapy	☐ Yes	☐ No

Are you on diet? ☐ Yes, if yes, what kind of? ☐ No

_____ since _____

Can you take care of yourself? ☐ Yes ☐ No
I do require assistance
○ eating / drinking ○ washing / personal hygiene
○ dressing ○ going to bathroom

Do you need a hearing device? ☐ Yes ☐ No

Do you wear glasses or contact lenses? ☐ Yes ☐ No

Do you wear removable dentures? ☐ Yes ☐ No

Do you need a walker? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Are or were you professionally exposed to toxic substances? ☐ Yes ☐ No
If yes, which one?

_____

Do you drink alcohol regularly? ☐ Yes, amount and kind of alcohol (wine, vodka) _____
☐ per day / ☐ per week ☐ No

Are you a smoker?
☐ Yes, since ____ years, ____ cigarettes per day
☐ no, I have never smoked
☐ no, I have not smoked for ____ years

Do you take any other narcotic substances on a regular basis?
☐ Yes, if yes which one? ☐ No

_____

Medication

Are you on regular medication?

☐ Yes ☐ No

Medication / dose	morning	midday	evening	night
e.g. Simvastatin 20mg			x	

Do you take blood-thinning medication?
(e.g. Aspirin, ASS, Clopidogrel, Eliquis, Heparin, Lixiana, Marcumar, Plavix, Pradaxa, Xarelto)

☐ Yes ☐ No

If yes, when did you stop taking it?

_____

Do you take cortisone medication? ☐ Yes ☐ No
Do you regularly take sleeping pills? ☐ Yes ☐ No
Do you regularly take laxatives? ☐ Yes ☐ No

Allergies / infectious diseases

Do you have any known allergies?

☐ Yes, since _____ ☐ No

If yes, which:

_____

_____

What reactions arrised to the allergies?

_____

Hospital germs risk profile

We need your help to protect you and other patients. You may have heard of multiresistant bacteria, such as methicillin-resistant Staphylococcus aureus (MRSA) or multiresistant gram-negative bacteria (MRGN). You may even unnoticed carry such a germ. However, in wounds or in immunodeficient people, these can lead to serious infections.

Was a MRSA or MRGN detected before? ☐ Yes ☐ No

Did you have contact with a person who has been diagnosed with MRSA or MRGN? ☐ Yes ☐ No

Have you had a hospital stay in the last 12 months?

- longer than 3 days ☐ Yes ☐ No
- outside of Germany ☐ Yes ☐ No

Do you live in Southern Europe, Great Britan or outside of Europe ☐ Yes ☐ No

Do you have professional contact with agricultural livestock ☐ Yes ☐ No

Are you a dialysis patient ☐ Yes ☐ No

Are you chronically in need of care? ☐ Yes ☐ No

Do you have poor wound healing (chronic) ☐ Yes ☐ No

Do you need a feeding tube ☐ Yes ☐ No

If you answered one of the questions with yes, we ask you to perform an screening (nasal swab for MRSA, Anal- and groin swab for MRGN). Please send the results latest 14 days prior to your operation.

Are you suffering or have you ever had one of the following infectious diseases:

Hepatitis B ☐ Yes ☐ No
Hepatitis C ☐ Yes ☐ No
HIV (AIDS) ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No

Cardiological risk profile

❶ **Do you have a heart condition**
(high blood pressure, CHD/coronary artery calcification, heart valve defect, cardiac arrhythmia)
☐ Yes ☐ No

❷ **Heart interventions**
Bypass operation ☐ Yes ☐ No
Heart catheter/stent ☐ Yes ☐ No

❸ **Chest pains / shortness of breath**
when climbing stairs up to 2nd - 3rd floor? ☐ Yes ☐ No

If you answered any of these questions with **Yes**:

Are your most recent cardiological findings older than six months? ☐ Yes ☐ No

If yes, a new assessment with an exercise ECG and echocardiography is necessary.

Note: In the case of coated stents, the operation is only possible after 6-12 month (double anticoagulation with ASS + Plavix is required for 6-12 month). More details must be discussed with the treating cardiologist.

Pre-existing conditions

Have you ever received a blood transfusion? ☐ Yes ☐ No

Do you suffer from one of the following diseases or one of the following symptoms?

[1.] Heart conditions

Cardiac arrhythmia ☐ Yes ☐ No
Myocarditis or heart valve inflammation ☐ Yes ☐ No
Heart attack ☐ Yes ☐ No
Heart valve defect ☐ Yes ☐ No
Heart failure (insufficiency) ☐ Yes ☐ No
Leg edema (water retention in the legs) ☐ Yes ☐ No
Dyspnea ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Coronary artery calcification (CHD) ☐ Yes ☐ No
Angina pectoris (paroxysmal dyspnea, chest pain when exposed to strain, cold etc.) ☐ Yes ☐ No

Other

[2.] Circulatory and vascular diseases

Thrombosis ☐ Yes ☐ No
Embolism ☐ Yes ☐ No
Varicose veins ☐ Yes ☐ No
Circulation disorders ☐ Yes ☐ No
Stroke ☐ Yes ☐ No

Other

[3.] Respiratory and lung diseases

Asthma ☐ Yes ☐ No
Chronic bronchitis ☐ Yes ☐ No
Pulmonary emphysema ☐ Yes ☐ No
Coughing or cold with fever ☐ Yes ☐ No
Sleep Apnea Syndrome ☐ Yes ☐ No
Do you sleep with a mask? ☐ Yes ☐ No

Other

[4.] Liver diseases

Fatty liver	☐ Yes	☐ No
Cirrhosis	☐ Yes	☐ No
Increased liver values	☐ Yes	☐ No
Gall stones	☐ Yes	☐ No

Other

[5.] Digestive tract

Pancreatitis	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No
Ulcerative colitis	☐ Yes	☐ No
Stomach ulcer	☐ Yes	☐ No
Reflux disease (acid regurgitation)	☐ Yes	☐ No
Gastritis	☐ Yes	☐ No
Intestinal polyps	☐ Yes	☐ No
Diverticula	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Proneness to constipation	☐ Yes	☐ No
Nausea and vomiting	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No

Unintentional loss of weight ☐ Yes ☐ No

If yes, how much _____/_____ kg/per month

Other

[6.] Metabolic disease

Diabetes	☐ Yes	☐ No
High blood fat values	☐ Yes	☐ No
Thyroid hyperfunction	☐ Yes	☐ No
Thyroid hypofunction	☐ Yes	☐ No

Other

[7.] Eyes

Retinal detachment	☐ Yes	☐ No
Cataract (clouding of the lens)	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Other

[8.] Neurological and mood disorders

Epilepsy	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Migraines	☐ Yes	☐ No

Other

[9.] Skeletal or muscular diseases

Bone or muscular atrophy	☐ Yes	☐ No
Bone fractures	☐ Yes	☐ No
Arthrosis	☐ Yes	☐ No
Rheumatism	☐ Yes	☐ No
Slipped disc	☐ Yes	☐ No

... ☐ was operated / ☐ was treated conservatively

Other

[10.] Blood

Deficiency of red blood cells	☐ Yes	☐ No
Deficiency of white blood cell	☐ Yes	☐ No
Deficiency of blood platelets	☐ Yes	☐ No
Blood clotting disorder	☐ Yes	☐ No
Current Hemoglobin level	_____	

Other

[11.] Other diseases and infirmities

(Non urological) operations

Have you been operated on before? ☐ Yes ☐ No

Date	Operation	Clinic

Previous urological diseases/operations/hospitalisations

☐ Yes ☐ No

Date	Operation	Clinic

[12.] Micturition behaviour

Pain when urinating ☐ Yes ☐ No

Frequent urge to urinate ☐ Yes ☐ No

Do you have blood in the urine? ☐ No

☐ Yes, since _____.

How often do you urinat? during the day: _____ times

at night: _____ times

Do you have a weakened stream of urine? ☐ No

☐ Yes, since _____.

Have you ever suffered from urinary retention? ☐ Yes ☐ No

Do you suffer from an involuntary loss of urine? ☐ Yes ☐ No

Are you currently wearing a permanent catheter? ☐ Yes ☐ No

If you are wearing a catheter, please let your urologist test your urine for bacteria two weeks before arriving at Martini-Klinik. In case of an urinary infection you have to start an antibiotic therapy.

[13.] PSA history

If PSA values have already been determined in the last few years, please enter the PSA values into the table below in chronological order:

Date	PSA	Date	PSA

[14.] Hormone therapy

Was an antihormonal therapy initiated? ☐ Yes ☐ No

If yes, since when, which medication?

Date start	Medication

[15.] Family history

Do any of your blood relatives (mother, father, siblings) have a malignant disease (cancer), or have had one in the past?

☐ Yes ☐ No

Who	which cancer/ fall ill at the age of

Has your family ever had a gene testing for a higher familial incidence of prostate, ovarian or breast cancer, and was it abnormal?

☐ Yes ☐ No

Date

Signature

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