

Answer the questions on both pages of this form. Don't forget to fill in your personal identification number and your full name. We might have to cancel the visit/operation if we miss answers on the questions.

Personal identity number: _____

Name: _____

Tel. home: _____

Other tel no: _____

 (*Underline the number you would prefer us to use*)

E-mail: _____

Next of kin:

Name: _____

Relationship: _____

Tel no: _____

HEALTH DECLARATION

- | | Yes | No | | | | | | | | | | | | |
|--|--------------------------|--------------------------|--------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------------------------|--------------------------|
| 1. Do you need an interpreter in your contacts with the medical services?
If Yes, what language do you speak? _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 2. Do you have or have you had any of the illnesses/conditions below? | | | | | | | | | | | | | | |
| Neurological illness (e.g. stroke, epilepsy, MS)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Cardiovascular diseases (e.g. heart attack, vascular spasm)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| High blood pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Lung disease (e.g. asthma, KOL)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Kidney disease..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Liver disease..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Rheumatic illness | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Blood contamination..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Psychological problems (anxiety, anguish, depression, dependency on prescription drugs/alcohol)
..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| Do you have any other medical problems or handicaps you think we should know about?

_____ | | | | | | | | | | | | | | |
| 3. Have you had an operation previously? If Yes – when, for what and at which hospital?
_____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 4. Have you regularly taken any medications or natural remedies over the past 3 months? If Yes, which?
<table border="0" style="width: 100%; margin-top: 5px;"> <thead> <tr> <th style="width: 40%; text-align: left;">Name of medicine</th> <th style="width: 20%; text-align: left;">Strength</th> <th style="width: 40%; text-align: left;">Dosage</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>
(please enclose a list of medications if appropriate) | Name of medicine | Strength | Dosage | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Name of medicine | Strength | Dosage | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | |
| 5. Are you allergic/hypersensitive to anything? (<i>e.g. prescription drugs, foods</i>)
or do you experience skin disorders from plasters?
If Yes, what? _____

What problems do you experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |

→ Please turn over, more questions on page 2 →

HEALTH DECLARATION

- | | Yes | No |
|---|--------------------------|--------------------------|
| 6. Do you smoke?
If Yes, how much and since when? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any metal objects surgically inserted? (<i>E.g. screws, plates, pins, pacemaker</i>)
If Yes, what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you or anyone in your family experienced problems in connection with general anaesthetic?
If Yes, who and what were the problems? _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you experience difficulty walking up 2 – 3 flights of stairs without a rest?
If Yes, why? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you experience chest pains when you exert yourself or in cold weather? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have a cough? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you suffer from sleep apnea?
If Yes – do you have special breathing aids, e.g. CPAP | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you suffer from gastritis or a gastric ulcer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you often have problems with heartburn or pyrosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you experience problems with acetylsalicylic acid (<i>E.g. Trombyl, Albyl, Magnecyl, Treo</i>) or what are known as NSAID preparations? (<i>Ipren, Ibumetin, Brufen, Naproxen, Orudis, Diklofenak</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have gall bladder problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you bleed easily? Do you have a known blood clotting disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you easily feel nauseous? (<i>Travel sick? After any previous operation?</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any body piercing?
If Yes – where? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you use contact lenses, a hearing aid or dentures?
If Yes – what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you received medical attention abroad or care at another hospital in Sweden in the past year, if so, where and when? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Your height _____ cm Your weight _____ kg

Date when filling in this form

Your signature

Do you have any special requests or points of view regarding your operation?
