|  |  |  |
| --- | --- | --- |
| First and Last Name | Birth Date | Address |
| Phone number at which you can be reached | | |
| Email address | | |
| Payer | | |
| Language Need an interpreter ☐ Yes ☐ No | | |

**PERSONAL DATA** Fill in form carefully (3 pages)

**HEALTH DATA AND PHYSICAL CONDITION**

|  |  |  |  |
| --- | --- | --- | --- |
| Length (cm) and Weight (kg) | Are you hypersensitive to any medicines? *To what/What are the symptoms?*  ☐ Yes ☐ No | | |
| Special diet  ☐ Yes ☐ No | Are you allergic? (Hay fever, food allergy etc.)  ☐ Yes ☐ No | | |
| Do you use drugs?  ☐ Yes ☐ No | Do you smoke?  ☐ Yes ☐ No | Cigarettes/day? | Given up, *when?* |
| How many units of alcohol you drink per week*on average*? | | Are you pregnant? When did you have your last menstrual period?  ☐ Yes ☐ No | |
| Do you do fitness training?  ☐ Yes ☐ No Less than 2,5 h/wk. ☐ 2,5 h – 5 h/wk. ☐ More than 5 h/wk. | | | |
| How far can you walk on a flat ground without stopping?  ☐ Less than 100 m ☐ More than 100 m ☐ Less than 1 km ☐ More than 1 km | | | |
| How many floors can you walk up the stairs without stopping?  ☐None ☐1 ☐2 ☐ 3 ☐More than 3 | | | |
| Is your mobility restricted by  ☐ Chest pain ☐ Lower limb pain ☐ Shortness of breath ☐ Other symptoms, *What?* | | | |
| Have there been any changes in your health in the past few months? *What?*  ☐ Yes ☐ No | | | |

**DISEASES** Do you have or have you had any of the following diseases?

|  |  |  |  |
| --- | --- | --- | --- |
| Congenital heart disease  ☐ Yes ☐ No *What?* | | Rheumatic disease  ☐ Yes ☐ No *What?* | |
| Valvural heart disease  ☐ Yes ☐ No *What?* | | Liver disease  ☐ Yes ☐ No *What?* | |
| Coronary artery disease  ☐ Yes ☐ No *What?* | | Kidney disease  ☐ Yes ☐ No *What?* | |
| Heart failure  ☐ Yes ☐ No | | Thyroid disease  ☐ Yes ☐ No *What?* | |
| Myocardial infarction  ☐ Yes ☐ No *Year?* | | Diabetes  ☐ Yes ☐ No *Since year?* | |
| Arrhythmia  ☐ Yes ☐ No | | Muscle disease  ☐ Yes ☐ No *Since year?* | |
| Cerebral embolism  ☐ Yes ☐ No *Year?* | | Epilepsy  ☐ Yes ☐ No | |
| Cerebral hemorrhage  ☐ Yes ☐ No *Year* | | Other neurological disease or disorder  ☐ Yes ☐ No *What?* | |
| Venous thrombosis  ☐ Yes ☐ No *Year?* | | Mental disease or disorder  ☐ Yes ☐ No *What?* | |
| Pulmonary embolism  ☐ Yes ☐ No | | Excess weight  ☐ Yes ☐ No | |
| Hypertension  ☐ Yes ☐ No | | Weight loss  ☐ Yes ☐ No | |
| Other heart or vascular disease  ☐ Yes ☐ No *What?* | | Impaired hearing  ☐ Yes ☐ No | |
| Bleeding tendencies  ☐ Yes ☐ No *What?* | | Anemia  ☐ Yes ☐ No | |
| First and Last Name | | Birth Date | |
| Other blood disease  ☐ Yes ☐ No *What?* | | Sleep Apnea  ☐ Yes ☐ No | |
| Asthma Chronic  ☐ Yes ☐ No | | Obstructive Pulmonary disease  ☐ Yes ☐ No | |
| Other lung disease *What?*  ☐ Yes ☐ No | | | |
| Condition of the teeth  ☐ Good ☐ Bad | The latest dental appointment? | | Ongoing treatment  ☐ Yes ☐ No |
| Have you had any isolation demanding, with regard to hospital hygiene significant bacteria/viruses (MRSA, ESBL, VRE, etc.)? ☐ Yes ☐ No | | | |

**PREVIOUS OPERATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| Have you had operations in the past?  ☐ Yes ☐ No | | | |
| Have you experienced prolonged postoperative pain requiring medical treatment?  ☐ Yes ☐ No | | | |
| Have you experienced other prolonged pain requiring medical treatment?  ☐ Yes ☐ No | | | |
| Do you have motion sickness?  ☐ Yes ☐ No | | | |
| Have you been hospitalized at home or at abroad during the past 12 months?  ☐ Yes ☐ No *Where?* | | | |
| operation 1 | year | hospital | ☐ General anesthesia  ☐ Local anesthesia | |
| operation 2 | year | hospital | ☐ General anesthesia  ☐ Local anesthesia | |
| operation 3 | year | hospital | ☐ General anesthesia  ☐ Local anesthesia | |
| operation 4 | year | hospital | ☐ General anesthesia  ☐ Local anesthesia | |
| At surgery did you have?  ☐ Nausea ☐ headache ☐ problems with waking up ☐ other, *What?* | | | | |

**ASSISTIVE DEVICES** (Do you use any of the following assistive devices)

|  |  |  |
| --- | --- | --- |
| ☐ Nasal CPAP | ☐ Glasses | ☐ Dental prosthesis |
| ☐ Wheelchair | ☐ Contact lenses | ☐ Bridges, pins etc. |
| ☐ Rollator | ☐ Hearing aid | ☐ Crutches |

**HOUSING AND CONTACT INFORMATION**

|  |  |  |
| --- | --- | --- |
| Housing  ☐ Apartment building ☐ Row house ☐ Single family house ☐ Other | | |
| Elevator  ☐ Yes ☐ No | | |
| Do you live alone?  ☐ Yes ☐ No | | |
| May the ward release information about your health? To whom?  ☐ Yes ☐ No | | |
| Do you receive assistance at home?  ☐ Yes ☐ No | Name of the provider of the assistance at home? | Phone number |
| Family doctor/health center | | |

|  |  |
| --- | --- |
| First and Last Name | Birth Date |

**MEDICATION AND DOSAGE**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you take or are about to take any regular medicine taken as needed prescribed by a doctor or purchased over the counter? ☐ Yes ☐ No | | | |
| Do you take regular or as needed any natural health products?  ☐ Yes ☐ No | | | |
| What pain medicine do you take or have taken? | | | |
| Have you taken cortisone pills during the last 6 months?  ☐ Yes ☐ No | | | |
| Do you take any medicines or natural health products that affect blood dotting?  ☐ Acetylsalicylic (Asperin®, Disperin®, Primaspan®, Asasantin®)  ☐Clopidogrel (Plavix®, Clopidogrel®)  ☐ Warfarin (Marevan®)  ☐ Omega 3- fish oil products  ☐ Other, **what**? | | | |
| **REGULAR MEDICATION** (Medicine name/strength: Burana® 400 mg, Dosering: 1 tab x 3 or 1 + 1 + 1) | | | |
| Medicine name/strength | Dosering | Medicine name/strength  Iltapäivä  Ilta | Dosering | |
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| **ON DEMAND MEDICINE: Medicine name/strength** | | | | |
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| **NATURAL REMEDIES OR VITAMINS: Name of natural remedies or vitamins** | | | | |
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**SIGNATURE**

|  |  |
| --- | --- |
| Date | Signature and name |