|  |  |  |
| --- | --- | --- |
| 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**

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| --- |
| 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**

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| --- |
| 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 IltapäiväIlta | 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 |