VÄSTRA GÖTALANDSREGIONEN
FRÖLUNDA SPECIALISTSJUKHUS

Health Declaration

Before your visit, we need the following information to plan your treatment in the best possible way.

PATIENT DETAILS

Telephone number	Civic registration number
Mobile telephone number	Name
E-mail address	Profession

Question	Answer
1a) Are you sensitive/allergic to any medicines? If Yes, which?	☐No ☐Yes
1b) Are you sensitive/allergic to anything else? ☐Latex ☐Nickel ☐Plaster ☐Soya Other:	☐No ☐Yes
2) Are you suffering or have your suffered from a cardiovascular disease? If Yes, which? ☐ High blood pressure (inclusive treated) ☐ Coronary surgery, angio plasty or stent insertion. When ☐ Heart attack. When ☐ Heart valve disorder ☐ Angina ☐ Arrythmia ☐ Pacemaker/ICD fitted	☐No ☐Yes
3) Do you suffer from a lung disease? If Yes, which? ☐ COPD ☐ Asthma ☐ Other:	☐No ☐Yes
4a) Do you smoke? If Yes, how much?	☐No ☐Yes
4b) Do you use "snus"? We recommend that you stop smoking or using "snus" before operation.	☐No ☐Yes
5a) Do you suffer from sleep apnoea?	☐No ☐Yes
5b) Do you use CPAP at home?	☐No ☐Yes
6) Do you find it difficult to walk 2–3 floors using the stairs without resting? If Yes, which symtom(s)? ☐ Chest pain ☐ Breathlessnes ☐ Muscel/joint pain	☐No ☐Yes
7) Do you have diabetes? If Yes, how do you treat your diabetes? ☐ Diet only ☐ Tablets ☐ Insulin	☐No ☐Yes

Question	Answer
8) Do you have a kidney disease? If Yes, which?	☐No ☐Yes
9a) Do you suffer from heartburn when you lie down or bend forward?	☐No ☐Yes
9b) Do you have an inguinal hernia?	☐No ☐Yes
9c) Do you have an intestinal disease? If Yes, which?	☐No ☐Yes
9d) Do you have a liver disease? If Yes, which?	☐No ☐Yes
10a) Have you ever had a blood clot?	☐No ☐Yes
10b) Have any of your parents, siblings or children ever had a blood clot?	☐No ☐Yes
10c) Do you bruise easily, have frequent nosebleeds or gums bleed?	☐No ☐Yes
11a) Have you ever had a stroke/seizure? If Yes, when?	☐No ☐Yes
11b) Do you have a neurological disease? If Yes, which? (e.g. epilepsy, Parkinson, MS)	☐No ☐Yes
12) Have you ever suffered pain that has persisted for more than three moths?	☐No ☐Yes
13) Do you have any other diseases, injuries or functional impairments? If Yes, which?	☐No ☐Yes
14a) Have you had any problems in the past with anaesthetics? If Yes, which?	☐No ☐Yes
14b) Are you prone to car or sea sickness?	☐No ☐Yes

15a) Do you have restricted neck movement?	☐No ☐Yes
15b) Do you find it difficult to open your mouth wide?	☐No ☐Yes
16a) Have you undergone any form of surgery in the past? If Yes, for what reason and at which hospital/clinic?	☐No ☐Yes
16b) Do you have anything metallic in your body thas has been fitted surgically?	☐No ☐Yes
17) Have you received care/worked at healthcare abroad during the past 12 months?	☐No ☐Yes

18) Do you have chronic blood infektion?If Yes, which? ☐ HIV ☐ Hepatitis B/C	☐No ☐Yes
19a) Is there a confirmed infection involving drug resistant bacteria, e.g. MRSA/VRE/ ESBL? If Yes, in whom? ☐ You ☐ A close relative	☐No ☐Yes
19b) Do you have any piercings? All piercings must be removed before operation.	☐No ☐Yes
If you are a woman 20a) Are you, or is it possible that you are pregnant?	☐No ☐Yes
20b) Do you use contraceptives or take medication containing oestrogen?	☐No ☐Yes

Do you take mediciation and/or use health food products on a regular basis? ☐No ☐Yes

If Yes, which? (Including analgesic tablets and contraceptive pills/vaginal ring)

Name of medicine/product	Strength	Dosage, number of tablets/dose				
		Morning	Lunch	Dinner	Evening	As necessary

If there is insufficient space, please enclose a list of medicines.

Other

Can journal copies be ordered from other healthcare providers? If Yes, which hosptial /medical centre/clinic?	☐No ☐Yes
In the event of an operation, can you arrange for an adult to be at home with you during the evening and night following your operation?	☐No ☐Yes
Name and telephone number (mobile phone and home/work phone) of a relative or person close to you	

Civic reg no ☐ Length ☐ Weight ☐ BMI ☐ (calulated at the clinic) Blood pressure ☐ (messured at the clinic)

.... Date .... Signature, patient .... Date .... Signature, doctor

New information	Date	Signature