

Health declaration

Name: _____

Personal identity number _____

Street address: _____

Postcode: _____

Telephone number: _____

To make sure you receive the best possible care, we need to gather some information about medical conditions and other factors that affect your health. Please ask our staff if there is anything you are unsure of.

<u>Mark with a cross</u>	<u>Details</u>
<input type="checkbox"/> Heart/cardiovascular	_____
<input type="checkbox"/> Blood/blood pressure	_____
<input type="checkbox"/> Blood infection	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Ears/sinuses	_____
<input type="checkbox"/> Pain/aches	_____
<input type="checkbox"/> Radiotherapy	_____
<input type="checkbox"/> Pregnancy	_____
<input type="checkbox"/> Smoker/use Swedish snus	_____
<input type="checkbox"/> Hypersensitivity	_____
<input type="checkbox"/> Medication	_____
<input type="checkbox"/> Currently being treated by a physician	_____
<input type="checkbox"/> In full health	_____
I am here today because:	_____