SOPHIA HEMMET
HÄLSOCENTRALEN

HEALTHCARE QUESTIONNAIRE

Date:_____

Name: _____Civic reg. no:_____

Home tel./mobile:_____Work tel./mobile:_____

Home adress:_____Profession:_____

☐ Married ☐ Partner ☐ Live apart ☐ Single Children ☐ Yes ☐ No

Your health assessment includes a consultation with a physician during which he/she will review this questionnaire, do a physical examination and go through your test results. Your replies will be kept strictly confidential. This questionnaire is intended solely as an aid in your health assessment.

Family medical history (e.g. heart infarction, stroke, diabetes, thyroid disease, colon cancer, glaucoma):

_____

_____

Your current and previous medical conditions/operations:

_____

_____

_____

Allergy? ☐ No ☐ Yes, allergic against: _____

I feel healthy ☐ Yes ☐ No

Current medication, contraceptives, supplements:

_____

_____

☐ Varied diet ☐ Diet restrictions:_____

Physical activity, number of times per week _____ Activity type _____

Smoking ☐ Never ☐ Quit year _____ ☐ Smoking, cigarettes per day _____

Other nicotine use ☐ No ☐ Yes, this (e.g. snuff, gum) _____

Alcohol ☐ Never ☐ Yes, this many units per week:

Wine (15 cl)	Beer (33 cl)	Spirit drinks (4 cl) e.g. whisky
Units:	Units:	Units:

Private health insurance ☐ No ☐ Yes, insured by this provider: _____