SOPHIAHEMMET SJUKHUS
Hälsocentralen

HEALTHCARE QUESTIONNAIRE

Date:.....

Name: _____

Civic reg. no: _____ Profession: _____

Home tel./mobile: _____ Work tel./mobile: _____

Home address: _____

FAMILY: ☐married ☐partner ☐live-apart ☐single

CHILDREN: ☐yes ☐no

Your health assessment includes a consultation with a physician, at which he/she will:
review this questionnaire, go through all your test results and give you a medical examination.

Your replies will be kept strictly confidential. You are under no obligation to answer all the questions.
This questionnaire is intended solely as an aid to your health assessment.

YOUR MEDICAL HISTORY

Serious diseases in the family: _____

Previous diseases: _____

Surgery (diagnosis-date-hospital): _____

Current diseases: _____

Do you have any allergies? _____

Which drugs and dietary supplements do you use (if any)? _____

_____

PTO

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YOUR LIFESTYLE

Exercise:	☐ never	☐ occasionally	☐ 1–3 times/week
	☐ >4 times/week	Type of exercise: _____	
Tobacco:	☐ never smoked		
	Quit smoking, year: _____		
	☐ smoke, number cig/day _____		Use snuff Yes/No
Alcohol:	☐ never	☐ yes	
Estimated consumption/week:	*beer cl* _____	*wine cl* _____	*spirits cl* _____
	☐ *reduced*	☐ *same*	☐ *increased*
Weight past 3 years:	☐ *reduced*	☐ *same*	☐ *increased*

I feel fit and healthy: ☐ yes ☐ no

Do you have a private health insurance? ☐ yes ☐ no

I seek advice on:

☐ dietary recommendations

☐ physical activity in the prevention of disease

Other: _____

_____