Vasa centralsjukhus
Vaasan keskussairaala

MY MEDICAL HISTORY

completed on_____ /_____ 20____

To provide safe treatment, we need to have accurate information about your health. Please fill in this medical history form carefully.
Send the form to the hospital as soon as possible or take the form with you, if you have an appointment at an outpatient clinic.

Name Identity code

Occupation Telephone Weight (kg) Height (cm)

Do you have or have you previously had any of the following?

Coronary heart disease	☐ No	☐ Yes
Myocardial infarction (heart attack)	☐ No	☐ Yes/When?
Heart valve disease	☐ No	☐ Yes
Heart failure	☐ No	☐ Yes
Arrhythmia	☐ No	☐ Yes
Cardiac pacemaker	☐ No	☐ Yes
Hypertension	☐ No	☐ Yes
Venous/pulmonary thrombosis	☐ No	☐ Yes/When?
Cerebral embolism / cerebrovascular accident	☐ No	☐ Yes/When?
Coagulation disorder / bleeding tendency	☐ No	☐ Yes
Asthma or other lung disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes, treated with ☐ insulin ☐ tablets
Thyroid disease	☐ No	☐ Yes
Liver disease	☐ No	☐ Yes
Kidney disease	☐ No	☐ Yes
Rheumatoid arthritis or other connective tissue disorder	☐ No	☐ Yes
Epilepsy	☐ No	☐ Yes / When did you have your last seizure?
Sleep apnoea	☐ No	☐ Yes / How is it being treated?
Mental health problems	☐ No	☐ Yes
Hepatitis, HIV, tuberculosis or other chronic infection	☐ No	☐ Yes / Please, specify
Other disease	☐ No	☐ Yes / Please, specify
Foreign implants in your body (such as artificial heart valves or joints)	☐ No	☐ Yes / Please, specify

Do you have chest pain? (please tick at least one box)	☐ At rest	☐ On light exertion	☐ On heavy exertion	☐ Never
Does nitro help?	☐ Yes	☐ No	☐ I don't use it	
Do you suffer from shortness of breath? (please tick at least one box)	☐ At rest	☐ On light exertion	☐ On heavy exertion	☐ Never

Current medication (including non-prescription medicines, such as analgesics, herbal products, vitamins or supplements, e.g. omega-3)

		Dosage, e.g. ½, 1 or 2 tablets			
Name of the medicine	**Strength** (e.g. 50 mg)	Morning	Noon	Night	Other dosage interval

Are you allergic

to medicines or local anaesthetics?	☐ No	☐ Yes	Please specify?	What reaction did it cause?
to rubber or latex?	☐ No	☐ Yes	Please specify?	What reaction did it cause?
to sticking plaster or tapes?	☐ No	☐ Yes	Please specify?	What reaction did it cause?
to something else (e.g. foodstuffs)?	☐ No	☐ Yes	Please specify?	What reaction did it cause?
Analgesics I can't tolerate:				

History of surgical operations or procedures:

Which operation/procedure?	When?	Which operation/procedure?	When?

Have you had problems in association with general or local anaesthesia? What kind of problems?
(e.g. nausea, allergic reaction, respiratory tract problems, other)

Have you received treatment or been examined in Finland within the past year?
(e.g. heart or lung examinations)

☐ No ☐ Yes

In which hospital? ______________________

Reason for the treatment or examinations: ______________________

Have you received treatment or been examined abroad within the last five years?
(e.g. heart or lung examinations, dental care)

☐ No ☐ Yes

In which hospital? ______________________

Reason for the treatment or examinations: ______________________

Are you a carrier of a multiresistent bacteria (e.g. MRSA, ESBL or VRE)?

☐ No ☐ Yes, which one and when was this found? ______________________

Do you consume alcohol?	☐ No	☐ Yes ☐daily ☐weekly ☐ less frequently
Do you smoke?	☐ No	☐ Yes _________ cigarettes/day, for __________ years
Do you take illegal drugs?	☐ No	☐ Yes Please specify

Do you have dental bridges, post crowns, dentures?

☐ No ☐ Yes / Please, specify ______________________

Are you pregnant?

☐ No ☐ Yes

Do you have anyone to escort you home on the day of surgery and a responsible person to support you during the night?

☐ Yes ☐ No

Other things to consider

☐ I will need an interpreter, language ______________________

What else would you like to tell us about your health or about your wishes concerning your treatment?

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Signature

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