DANDERYDS SJUKHUS

Health Questionnaire

Name .....**Date** .....

Swedish personal ID number (or date of birth, if not applicable).....

Home phone and Mobile phone .....**IMPORTANT!**

Primary care physician .....
(Name, office location)

Current complaint (describe briefly why you are now seeking medical care):

.....

.....

SOCIAL

Do you live alone? No ☐ Yes ☐ House ☐ Apartment ☐ .....floor With elevator ☐

Home care? No ☐ Yes ☐ .....hours/day.....days/week

Nursing home? No ☐ Yes ☐ .....

Do you have anyone available to assist you after your surgery? No ☐ Yes ☐

Hereditary disease in your family? .....

PREVIOUS SURGERIES

1. ..... Year ..... Hospital? .....
2. ..... Year ..... Hospital? .....
3. ..... Year ..... Hospital? .....
4. ..... Year ..... Hospital? .....

Have you had			**Complication?**		
- Local anaesthesia?	No ☐	Yes ☐	No ☐	Yes ☐	Describe .....
- Spinal/epidural?	No ☐	Yes ☐	No ☐	Yes ☐	Describe .....
- General anaesthesia?	No ☐	Yes ☐	No ☐	Yes ☐	Describe .....

PREVIOUS DISEASES

Heart attack?	No ☐	Yes ☐	Year	Hospital?.....
Other heart disease?	No ☐	Yes ☐	Year	Hospital?.....
Lung disease?	No ☐	Yes ☐	Year	Hospital?.....
Kidney disease?	No ☐	Yes ☐	Year	Hospital?.....
Jaundice?	No ☐	Yes ☐	Year	Hospital?.....
Other diseases?	No ☐	Yes ☐	Describe below	

.....Year .....Hospital?.....

.....Year .....Hospital?.....

.....Year .....Hospital?.....

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CURRENT DISEASES (other than the complaint you are now seeking care for)

Chest pain? No ☐ Yes ☐ How often?.....

Other heart disease? No ☐ Yes ☐ Describe ……

Hypertension? No ☐ Yes ☐ Since when?.....

Shortness of breath? No ☐ Yes ☐ Describe ……

Lung disease/asthma? No ☐ Yes ☐ Describe ……

Kidney disease? No ☐ Yes ☐ Describe ……

Liver disease? No ☐ Yes ☐ Describe ……

Diabetes? No ☐ Yes ☐ Insulin? No ☐ Yes ☐ Since when? ……

Seizure disorder? No ☐ Yes ☐ Seizures how often? ……

Bleeding tendency? No ☐ Yes ☐ Discribe .....

Other disease? No ☐ Yes ☐ Discribe .....

CURRENT MEDICATIONS

Name of drug	Strength	Morning	Midday	Evening	Night	As needed
Example: Tylenol, tablet	500 mg	2	2	2	0	0

Have you had cortisone (e.g., prednisone) in the last year? No ☐ Yes ☐ For how long? ……

Allergy/hypersensitivity to medications, or contact allergy? No ☐ Yes ☐ Discribe.....

Have you had health care outside Sweden in the past six months? No ☐ Yes ☐

Are you a carrier of MRSA? No ☐ Yes ☐ VRE? No ☐ Yes ☐ ESBL? No ☐ Yes ☐
(Methicillin resistant staph aureus) (Vancomycin resistant enterococcus)

Have you ever been diagnosed with MRSA or VRE? Please contact this office before your visit. This is important in order to prevent the spread of these bacteria.

Do you use herbal or natural medicine? No ☐ Yes ☐ Which?.....

SMOKING

Do you smoke? No ☐ Yes ☐ If yes, how much?.....

Did you ever smoke? No ☐ Yes ☐ If yes, how much?……Quit when?.....

Height:.....cm Weight:..... kg

Women of fertile age. Are you pregnant? No ☐ Yes ☐ Date of last period?. ……

You will see a physician anaesthetist or nurse anaesthetist on the day of your surgery. Do you need to see an anaesthetist earlier? No ☐ Yes ☐

Thank you for filling out this questionnaire!

Mail in envelope if enclosed, otherwise bring to your preoperative office visit.

DANDERYDS SJUKHUS
Kvalitet och omtanke