u·sote Uudenkaupungin sosiaali- ja terveyspalvelut

Social and health center /Sosiaali- ja terveyskeskus
Health services /Terveyspalvelut
Occupational Health Care /Työterveyshuolto

HEALTH INFORMATION

LABQUALITY SHQS-LAADUN-TUNNUSTUS

This form is ment to help us to evaluate the state of Your health aswell as your suspectability to illness. Complete the form carefully and take it with you to your Health Assessment to assist Occupational health care staff to make an accurate evaluation of your condition. Your information is strictly confidential and will be attached to your medical records.

1.Personal data	**Surname and first names**		**Social security number**	
	Vacational education and year of graduation		**Home address**	
	Profession and position of present employer			
2.Work history	**Previous employments**	**Duration**	**Occupation**	**Health assessment yes/no**
	Have you been ever been subjected to ☐ Noise ☐ Dust ☐ Solvents ☐ Shift work ☐ Other health hazards			
	Have you been diagnosed with any occupational diseases/work related symptoms ☐ No ☐ Yes			
	Present employer/department and superior		**Do you work some where else at the same time?** ☐ No ☐ Yes, where?	
3.Family history	**Have members of your family had any of the following illnesses or disorders?** ☐ Diabetes ☐ Hypertension ☐ Cardiovascular disease ☐ Diseases of the thyroid gland ☐ Asthma, Allergy ☐ Rheumatoid arthritis ☐ Mental disorder ☐ Cancer or malignant tumor ☐ Alcohol abuse ☐ Glaucoma ☐ Other, what?			
4.Personal evaluation	**How would you evaluate you own state of health (physical/psychological)** ☐ Excellent ☐ Good ☐ Fair ☐ Poor			

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5.Health related issues	**Have you suffered any of the following diseases or disorders?** ☐ Diabetes ☐ Hypertension ☐Chest pain ☐Cardiovascular diseases ☐Asthma ☐Skin disease ☐ Allergy ☐ Other respiratory disease ☐ Epilepsy ☐Migraine ☐ Persistent dizziness ☐ Disease of the prostate ☐Eye disease ☐ Ear disease, hearing impaiment ☐Rheumatoid arthritis ☐ Other musculoskeletal disease ☐Anemia, iron deficiency ☐Liver disease ☐Disease of thyroid gland ☐ Other disease of the digestive tract ☐Urinary tract infections ☐Kindney troubles ☐Cancer, tumors ☐ Other long-term illness ☐Sleeping disorder ☐ Mental disorder ☐ Abuse of alcohol, drugs or medication ☐ Other operation ☐ Serious injury ☐Coronary disease ☐ Benign tumor ☐Gout ☐ Pneumonia ☐ Tuberculosis
	In case you answered "Yes" in any of the fields above, please give details:
	Medication / **Medication when necessary**
	Medication allergies Tetanus Other
	Last examination Mammography year Chest x-ray year Eyesight test y.ear Do you wear glasses ☐Yes ☐No Color blindness ☐Yes ☐No
6.Living habbits	**Do you smoke?Including pipe, chew tobacco, electric tobacco and snus** ☐ No ☐Occasionally ☐Yes, what? How often?
	How often do you consume alcohol? ☐ Never ☐Daily ☐ Weekly ☐Monthly ☐ Rarely
	Do you abuse drugs or medication? ☐ No ☐Yes, what?
Physical exercise habbits: **Other hobbies:**	
How many hours do you sleep in Are happy with the quality of your sleep ☐ Yes ☐No Do you feel tired during the day ☐ Yes ☐No	**Do you have a special diet?** ☐No ☐Yes, what?
7. Signature	**I hereby declaire that the statements made by me above are, to the best of my knowledge, true, complete and correct.** Date: Signature:

ÄP/2019