



Wellbeing services county of Central Ostrobothnia Soite

Form on case history: doctor's reception
Physiatrics and rehabilitation assessment

Please fill in this form on your case history carefully and take it with you to the reception. The information given on this form is confidential and helps us to carry out you care.

Family name:

Given names:

Social security number:

Address:

Post code:

Town:

Municipality of residence:

Telephone number/home:

Telephone number/work:

Occupation:

Employer:

Height:

Weigh:

Age:

- a cardiovascular disease
- high blood pressure
- a pacemaker
- asthma, lung disease
- diabetes
- a blood disorder, anaemia
- tendency to bleed easily
- epilepsy
- repeated headache
- rheumatism
- thyroid disease
- a stomach ulcer
- a kidney disease
- a liver disease
- a stroke
- a mental health disorder
- cancer
- a venous thrombosis
- a pulmonary embolus
- an infectious disease (hepatitis B, C or an HIV infection)
- an endoprosthesis or foreign material in the body, where:

- some other systemic diseases, what:

Past operations (operation and year):

Are you pregnant or breastfeeding:

Your current state of health:

good fairly good bad

Smoking:

no yes, cigarettes/day: how long:

Alcohol use:

I don't use I use, drinks/week:

The medication you use (the name of the medicine, its strength and dose, e.g. Panadol 500 mg 1 x 3:)

Physical activity (type of activity/sport, times/week, length minutes/occasion):

Do you use a medicine that affects blood coagulation (e.g. Marevan, Plavix, Primaspan), what:

Are you hypersensitive or allergic to medicines or other substances, what:

Other further information:

What do you wish for concerning your visit to the reception:

Date

Signature and name in block letters