Preliminary information form for health care and treatment

You have an appointment on: ____ / ____ 20 ____ at __________

This preliminary information form you have filled out will be used to help us draw up a health care and treatment plan for you together with you. The purpose of the health care and treatment plan is to support you in maintaining your own health and in the self-care of illnesses. There are also free-format questions in the questionnaire, and we hope that you will tell us about matters that press your mind so that we can take your situation into account more comprehensively. Take this preliminary information form and recent home monitoring forms (e.g. blood pressure, blood sugar, PEF, weight) with you to the appointment.

Name:	Date of birth:
The following person helped me in filling out the form:	Date:

My illnesses:

Has either one of your parents had a myocardial infarction?
No ☐ Yes ☐ I do not know ☐

Has either one of your parents had a stroke?
No ☐ Yes ☐ I do not know ☐

Housing:

Apartment building ☐ Terraced house ☐
Semidetached house / detached house ☐ Service home ☐
Other ☐ What?
Describe your housing in more detail (e.g. do you live with someone else):

Work situation / subsistence:

Student ☐ Working ☐ Unemployed ☐ Retired ☐
Other ☐ What?
On sick leave ☐ On rehabilitation allowance ☐ Specify which period:

My own assessment of my wellbeing:

I hope there will be a change in this:

This is how I could promote my own well-being:

I hope to receive this kind of support:

Surgeries / endoscopic examinations performed, and year:

Allergies (medication, food etc.):

Nicotine products, alcohol and other intoxicants:

Smoking

No ☐ Yes ☐ cigarettes per day I stopped smoking ☐ In (year):

I use other nicotine products (e.g. snuff, nicotine bag or e-cigarettes):

No ☐ Yes ☐ What?

I use alcohol:

No ☐ Yes ☐ doses per week (1 dose = 0.33 litres of medium beer / 0.12 centilitres of wine / 4 centilitres of spirits)

I use other substances (e.g. drugs):

No ☐ Yes ☐ What?

I have challenges in the use of intoxicants or the management of other addictions (e.g. narcotics or gambling):

No ☐ Yes ☐

People close to me have been worried about one of the above:

No ☐ Yes ☐

Weight:	**Height:**

Other care providers (e.g. private physician, occupational health care, mental health centre, TAYS):

Assistive equipment

No ☐ Yes ☐ What?

Need for assistance (e.g. washing, cleaning, paying bills, going shopping):

Hobbies and physical activity:

Eating

Breakfast ☐ Lunch ☐ Snack ☐ Dinner ☐ Evening snack ☐

Positive things about my eating habits:

Things that require improvement in my eating habits:

I have been examined by an oral hygienist or a dentist in the past two years (excluding appointments of an emergency nature):

No ☐ Yes ☐

I have experienced physical (e.g. pain), mental or social discomfort in the state of health of my mouth or teeth during the past month:

No ☐ Yes ☐

Sleep

I think I sleep well enough: No ☐ Yes ☐

I would like to discuss the following issues related to sleep:

Mental well-being

The following things bring joy to my life / help me cope in everyday life:

I am worried about the following things or my self-treatment is complicated by the following things:

Sexuality and sexual health (fill in the sections concerning yourself)

Latest gynecological check-up:	Prostate disorders:
Latest papilloma virus screening::	Erectile dysfunction:
Latest mammography:	

I would like to talk about:

Rehabilitation received (e.g. medical rehabilitation or rehabilitation psychotherapy):

MEDICATION USED BY ME			
Medicine and its strength For example, Atorvastatin 20 mg	Dose 1 tablet x 1	Purpose of use For high cholesterol	Tick if you only use the medicine if needed
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

SELF-CARE MEDICATION AND BIODYNAMIC PRODUCTS			
Medicine and its strength	Dose	Purpose of use	
			☐
			☐
			☐
			☐