Medical Report Form/Occupational Health

Full name:						Social security number:		
Home address:						Phone:		
						E-mail:		
Employer:		Starting date of employment:				Occupation:		
Office:		Education:						

Previous employment, employer (over 6 months)	Duration of Employment year-year	Occupational duties	Exposures of work (noise, vibration, solvents, dust ect.)	Medical examination Done	No
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
Occupational disease/ disability:	No ☐	Yes ☐			
Extra work:	No ☐	Yes ☐ What kind of:			

Evaluation of your health						**Work ability in scale 1 – 10:**
☐	Well	☐	Moderate	☐	Poor	

How many days have you been on sick leave during the last 12 months?

Hight, cm:	Weight, kg:	BMI:	Waistline, cm:

Smoking tobacco	☐	No	☐	Yes, Daily quantity? For how many years?	☐	Stopped smoking, years/months ago:

Any other nicotine-containing products?

Alcohol use	☐	Never	☐	Seldom	☐	Monthly	☐	Weekly
	☐	Daily	Number of standard drinks?					
Any other drugs	☐	No	☐	Yes	What kind of drugs and how often?			
Do you eat	☐	Regularly	☐	Diversely	☐	Healthy		

Diets, allergies

Do you exercise	☐	No		☐	Yes. What kind of and how often?

How many hours do you usually sleep at night?

Terveydentila	Do you have or have you ever had any of the following?				
☐	Eye disease	☐	High blood pressure	☐	Gastric ulcer
☐	Eyeglasses	☐	Arrhythmia	☐	Digestive disease
☐	Color blindness	☐	Chest pain in rest	☐	Gall stones
☐	Ear disease	☐	Chest pain when active	☐	Hepatitis
☐	Hearing loss	☐	Coronary artery disease	☐	Other liver disease
☐	Migraine	☐	Heart attack	☐	Blood in stool
☐	Other repeated headache	☐	Pain in calves when walking	☐	Hernia
☐	Dizzines	☐	Varicose vein	☐	Kidney stones
☐	Loss of consciousness	☐	Leg sore	☐	Kidney disease
☐	Other neurological disorder	☐	Cramps	☐	Diabetes
☐	Epilepsy	☐	HIV/AIDS	☐	Thyroid disease
☐	Stroke	☐	Pneumonia	☐	Benign tumor
☐	Anemia	☐	Asthma	☐	Malign tumor, Cancer
☐	Long-term insomnia	☐	Long-term cough	☐	Severe injury
☐	Mental Illness	☐	Tuberculosis	☐	Unconsciousness or vomiting after an accident
☐	Iskias, other back pain	☐	Other pulmonary disease	☐	Other allergy
☐	Rheumatoid arthritis	☐	Dyspnea in rest	☐	Other operation
☐	Gout	☐	Dyspnea when active	☐	Other disease
☐	Other joint disease	☐	Skin disease, eczema	☐	Other symptoms
☐	Physical therapy	☐	Allergy to pollen		

Additional information: If you answer ”Yes” to any item in this question please give details below

Found (year)	Situation today	Where was treated	When treated

Medication

Prescription drugs in use:

Other drugs in use:

Allergies to drugs:

Vaccination	**Year**		**Year**
Tetanus + diphteria		Chicken pox	
MPR (measles, rubella, mumps)		A-hepatitis	
Pertussis		B-hepatitis	

I declare that the information given is correct.

Date	Signature