TYÖTERVEYS WELLAMO



## 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 |
|---|---|---|---|---|---|
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| | | | | | |
| | | | | | |
| 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? | | Stopped smoking, years/months ago: |
|---|---|---|---|---|---|---|
| | | | | For how many years? | | |
| 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** |
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| 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 |
|---|---|
| | |