VESTRE VIKEN

Name and date of birth

SELF DECLARATION – HEALTH INFORMATION

NB! **BOTH SIDES** of this form should be filled out.
NB! **If you fill out at home: BRING IT WITH YOU when you come to the appointment.**
NB! If there is anything you are unsure about get in touch wth your general practitioner
If you tick YES to any of the questions, please bring documentation of this with you, for example copy of the consultation with the spesialist.

QUESTION AND ANSWER : TICK NO or YES, and which type of operation / illness			For hospital notes
Previously operated ? (where and when?)	**No** ☐ **Yes** ☐	☐Specify:.....	
Problems with previous Anesthetic?	**No** ☐ **Yes** ☐	Type of problem?	
Heart Disease ? (hospitalized? Where and when?) Last blood pressure measured (date and value)	**No** ☐ **Yes** ☐	☐Bypass operation ☐ Heart stent ☐ Heart flap ☐Heart attack ☐High blood pressure Arrythmia ☐Angina ☐ Breast pain ☐ Palpitations ☐ Fainting ☐ Other	
Lung Disease? (hospitalized? Where and when?)	**No** ☐ **Yes** ☐	☐Asthma ☐ Kols ☐ Emphysema ☐ Snoring/sleep apnea ☐Use CPAP Wheezing ☐ Other	
Kidney, Liver, or Stomach Disease? (hospitalized? Where and when?)	**No** ☐ **Yes** ☐	☐Kidney disease ☐ Liver disease ☐Esophageal hernia ☐Acid regurgitation ☐Stomach ulcer ☐other	
DIABETES? (hospitali **Metabolic disease ?**	**No** ☐ **Yes** ☐	☐Diabetes treatment: ☐ Diet ☐ Tablets ☐ Insulin ☐If diabetes: Last HbA1c measured (date and value):	
Recent Infection?	**No** ☐ **Yes** ☐	☐Covid-19 ☐ Urinary tract ☐ Respiratory tract ☐Teeth ☐Other?	
Infectious Disease?	**No** ☐ **Yes** ☐	☐Hepatitis ☐ HIV ☐ Tuberculosis ☐ Other?	
Admitted to hospital/ Operated abroad?	**No** ☐ **Yes** ☐	☐Testet for MRSA (resistant bacteria).? Date: ..... ☐Admitted to hospital / dental treatment abroad wthin the last 12 months	
Previous Blood clot?	**No** ☐ **Yes** ☐	☐Leg ☐ Lungs ☐ Brain ☐Eyes ☐Hereditary blood clotting tendancy ☐ Other?	
Blood Disease?	**No** ☐ **Yes** ☐	Specify	
Brain/ Neurological Disease	**No** ☐ **Yes** ☐	☐ Epilepsy ☐ MS ☐ Parkinson ☐ Stroke ☐Other / specify	
Cancer?	**No**☐ **Yes** ☐	Type of cancer / year / treatment ?	
Other illnesses?	**No** ☐ **Yes** ☐	Specify.....	

Other questions:			For sykehusets notater
Allergy ?	**No** ☐ **Yes** ☐	☐Medication ☐ Anesethesia – specify ☐Other Allergies – specify	
Blood thinners? **(remember medication list!)**	**No** ☐ **Yes** ☐	☐Albyl E ☐ **Asasantin** ☐ **Marevan** ☐ **Lixiana** ☐Plavix/ Brilique/ Efient ☐ Xarelto/ Eliquis/ Pradaxa	
Other medication? **(remember medication list!)**	**No** ☐ **Yes** ☐	**Name of tablets and dosage:**	
Smoke? **Snus/snuff?** **Other drugs?**	**No** ☐ **Yes** ☐ **No** **Yes**	☐Daily ☐Now and then ☐ **Stopped** (when?) ☐Daily ☐Now and then ☐ **Stopped** (when?) Specify.....	
Do you drink alcohol?	**No** ☐ **Yes** ☐	Units per week.....(1 unit = 1 gl beer/wine or 1 drink)	
Your height..... **CM**		**Your weight** ..... **KG**	**For Legen på MHH:** Blodtrykk: Puls: Cor: Pulm: Halskar:
Date of birth : ..... **DATE:**		**NAME (capital letters)** ..... **SIGNATURE:**	
NB! MEDICATION LIST!		**Please bring a list of your medications, including dosage from your General Practitioner.**	

For bruk på sykehuset: For use by the hospital ☐ Skjema scannes for mulig senere bruk

☐ Pas er ortopedisk klarert og meldt til Inntakskontoret for operasjon (DIPS)

☐ Pas er henvist til ortopedisk tilleggs-u.s., og svar må foreligge før opr. Type u.s.: .....

☐ Det skal innhentes ort. tilleggsopplysninger (for hva, fra hvor og når): .....

Antikoagulasjonsbehandling: ☐ Standard regime ☐ Se 'Kommentar'-feltet i DIPS

Pasientens papirer skal vurderes av anestesilege: ☐ **Nei** ☐ **Ja** – Pasientens papirer skal vurderes av anestesilege

Hvis tvil om anestesimessig klarering – ring **2525** (vakthavende anestesi-lege)

☐ **NB! Det skal innhentes medisinske tilleggsopplysninger:** .....
(type dokument, hva det gjelder, hvor og når vurdert)

☐ **Pasienten er henvist til ekstern spesialist for:** .....

☐ **Pasienten er henvist til rtg c-col. med problemstilling:** .....

☐ **Det er bedt om oppfølging hos fastlege for:** .....

Date...../...Init. ortoped..... / ...Sign ortoped .....