Diakonhjemmet Hospital

QUESTIONNAIRE ABOUT HEALTH INFORMATION BEFORE A HOSPITAL VISIT

We ask you to fill in and submit this form before you come to the hospital. Send your answer to the hospital and the department that called you in (see information in the letter). You can also log in to helsenorge.no via the link provided in the invitation letter and fill in the form there. The questionnaire will first be read in connection with your appointment, not as soon as you submit it. You will not receive a reply.

Personal information and next of kin		
Surname:	Given name:	
Middle name:	Norwegian national identity number (11 digits):	
Telephone private/mobile:	Next of kin:	
Norwegian national identity number next of kin (11 digits):	Telephone private/mobile next of kin:	
Do you have sole responsibility for children under 18 or others with special care needs?	☐ Yes ☐ No	
Do you have one or more employers?	☐ Yes ☐ No	
Employer's name	Profession/position	Employment rate
Health		
Do you have, or have you had, any of the diseases below? Tick and answer the questions		
☐ Cardiovascular disease	Which cardiovascular disease?	
Do you have a pacemaker? Do you know which pacemaker you have?	☐ Yes ☐ No	
If you have had heart surgery, we ask you to answer a few additional questions Blockage of the coronary arteries in the heart (PCI)? When and where did you have the surgery?	☐ Yes ☐ No	
Open heart surgery on the heart's coronary arteries (bypass surgery)? When and where did you have the surgery?	☐ Yes ☐ No	

Heart valve surgery? ☐ Yes ☐ No When and where did you have the surgery?	
☐ High blood pressure (hypertension)	Is your blood pressure well controlled with medication? ☐ Yes ☐ No ☐ Don't know
☐ Increased tendency to bleed or do you use blood-thinning medication? Tick the box that applies to you: ☐ Blood thinning medications ☐ Bleeding disease or other coagulation disorders (disorders in the clotting ability of the blood) ☐ Other bleeding tendency	
☐ Lung disease	What lung disease? Do you use oxygen at home? ☐ Yes ☐ No
☐ Sleep apnea	Do you use a breathing mask when you sleep? ☐ Yes ☐ No *Take the breathing mask with you if you are going to be admitted overnight at the hospital.*
☐ Neurological disease	Which neurological disease?
☐ Kidney disease	Which kidney disease?
☐ Liver disease	Which liver disease?
☐ Diabetes	Which type of diabetes?
☐ Metabolic disease	Which metabolic disease?
☐ Arthritis or musculoskeletal disease	Which arthritis or musculoskeletal disease?
☐ Stomach or intestinal problems	What kind of stomach or intestinal problems?

☐ Mental illness	What mental illness?
☐ Contageous disease	Which contageous disease?
☐ Cancer	What kind of cancer and what kind of treatment?
☐ Other illness	Which other illness?

Do you get chest pains or become short of breath when you go up two flights of stairs at a normal pace?

☐ Chest pains ☐ Shortness of breath ☐ Cannot walk up stairs ☐ None of these

Height in centimeters:	Weight i kilograms:

Medicines and allergies

Do you use medication? ☐ Yes ☐ No

(Including any contraceptives, over-the-counter medicines, alternative medicines, and natural medicines).

Bring an updated medicine list to the appointment. You can get this at the pharmacy or from your GP.

List the name of any medicines, strength, and type (for example tablet, drops or syringe) and how much of the medicine you take each day

Are you allergic to any medications? ☐ Yes ☐ No

Which medicines (name of medicine, strength, and form) and what kind of reaction?

Are you allergic to any foods, pollen, latex, nickel or anything else? ☐ Yes ☐ No

What are you allergic to and what kind of reaction?

Have you previously reacted to contrast media in connection with x-ray examinations? ☐ Yes ☐ No

What kind of reaction? ☐ Don't know

Food, lifestyle and daily life

Do you need a special type of food? (tick one or more boxes)

☐ Diabetes diet ☐ Lactose-free diet ☐ Vegetarian diet

☐ Gluten-free diet ☐ Milk protein-free diet ☐ Food allergy

☐ Halal diet ☐ Salt-reduced diet ☐ Other special diet

☐ Kosher diet ☐ Vegan diet

Which other special diet?

Do you have problems with showering, dressing, and carrying out daily tasks yourself? ☐ Yes ☐ No

What do you need help with? Do you use aids? Do you have a personal assistant?

Do you have problems with seeing, hearing, or speaking that we should consider? ☐ Yes ☐ No

Describe:

How often do you smoke? ☐ Never ☐ Seldom ☐ Weekly ☐ Daily

Did you used to smoke? ☐ Yes ☐ No

How often do you use snus? ☐ Never ☐ Seldom ☐ Weekly ☐ Daglig

How often do you drink alcohol? ☐ Never ☐ Seldom ☐ Weekly ☐ Daily

How many units daily or weekly?

Do you use other drugs? ☐ Yes ☐ No

(We ask this because it may affect how you react to anesthesia, pain relievers and other medications. The hospital does not report you to the police if you answer yes to questions about the use of illegal drugs)

Describe type and frequency:

Before any operation or examination under general anesthetic or other anesthesia	
Have du been under general anesthetic previously	☐ Yes ☐ No
Have you or any of your relatives reacted to general anesthetic or other anesthesia? Who reacted, what kind of anesthesia and what kind of reaction did they have?	☐ Yes ☐ No ☐ Don't know
Do you have problems moving your jaw or neck, or opening your mouth wide? Descibe the problem:	☐ Yes ☐ No
Do you have teeth that have been repaired or are loose (bridge, denture, post, implants)? Describe what:	☐ Yes ☐ No
Do you have problems lying flat on your back? Describe what kind of problems:	☐ Yes ☐ No
Do you have heartburn, stomach ulcers, stomach catarrh, oesophageal hernia, acid reflux or similar? Describe your condition:	☐ Yes ☐ No ☐ Don't know
Do you have sores or rashes on the skin near the operation site? Give a short description:	☐ Yes ☐ No
It is recommended to have an adult with you for the first 24 hours at home after an operation. Do you have such a helper who can be with you at first 24 hours after the procedure/examination?	☐ Yes ☐ No

Questions about the appointment	
Do you need an interpreter? Which language?	☐ Yes ☐ No
Can you come to an appointment at short notice?	☐ Yes ☐ No
Help us prevent infection	
In order to give you and other patients in the hospital safe treatment, you must be tested for resistant bacteria if you answer yes to one or more of the points below. **During the last 12 months, have you:**	
Been infected by or lived in the same household as a person who has been infected by resistant bacteria (MRSA, VRE or ESBL)?	☐ Yes ☐ No
Worked as a healthcare worker or been admitted to a hospital or other healthcare institution outside the Nordic region?	☐ Yes ☐ No
Received extensive examination, treatment, injections or dental treatment in a health service outside the Nordic region?	☐ Yes ☐ No
Stayed in a refugee camp or orphanage outside the Nordic countries?	☐ Yes ☐ No
Stayed continuously for more than 6 weeks outside the Nordic countries and you also have chronic eczema, wounds or skin infections?	☐ Yes ☐ No
If yes: Test yourself for resistant bacteria at your GP. You must test yourself in good time before attending the hospital. The test is free. Contact the hospital if you are unsure whether you need to be tested. ***Call us as soon as possible if you know that you or someone you live with has or has had resistant bacteria.***	
Is there anything else we should know in order to provide you with good treatment?	

Place/Date _____ Signature _____