Inquiry into the state of health Date

PERSONAL DATA

1. Name:	2. Date of birth:	3. Country of birth: 4. Place of birth:
5. Adress in Finland:		6. Telehone:
7. Insurance: No Γ Yes Γ		8. Name of the insurance company:
9. Close parent or person to contact		10. Telephone:
11. School / study field /main subject:		12. Date of starting studies: 13. Expected graduation date:

HEALTH

14. State of health: Good Γ		Rather good Γ	Bad Γ
15. Do you have any longtime disease?	No Γ	Yes Γ	Which one?
16. Do you have a hepatic disease?	No Γ	Yes Γ	Which one?
17. Do you have HIV?	No Γ	Yes Γ	
18. Do you smoke or chew tobacco?	No Γ	Yes Γ	Which one and how much?
19. Do you drink alcohol or take other intoxicants?	No Γ	Yes Γ	Which one and how much?
20. Earlier hospitalizations or surgery?	No Γ	Yes Γ	For which reason?
21. Do you have allergic reactions?	No Γ	Yes Γ	To which medicine?
22. Have you had tuberculosis?	No Γ	Yes Γ	When?
23. Have you had medication for tuberculosis?	No Γ	Yes Γ	When? Which medication?
24. Have you had tuberculosis among your close relations (among persons living with you in the same household)?	No Γ	Yes Γ	

Do you have now or have you had earlier following symptoms:			If yes, give more details (f.i. when have you had symptoms, do you have them currently, is their origin known):
25. Cough since several weeks	No Γ	Yes Γ	
26. Sputum or haemophysis	No Γ	Yes Γ	
27. Nondeliberate loss of weight	No Γ	Yes Γ	
28. Night sweat	No Γ	Yes Γ	
29. Prolonged fever	No Γ	Yes Γ	
30. Swelling, pain or secreting of lymph nodes (neck, underarm, groin)	No Γ	Yes Γ	

MEDICATION AND VACCINATIONS

31. Do you take medicines with prescription? No Γ Yes Γ Which one(s)?		
Have you got the following vaccinations:		
32. Polio No Γ Yes Γ, when?	33. Tetanus/ diphtheria No Γ Yes Γ when?	34. Measles/ mumps/ rubella No Γ Yes Γ when?
35. Have you had measles? No Γ Yes Γ		
36. Have you had mumps? No Γ Yes Γ		
37. Have you had rubella? No Γ Yes Γ		