Support: 694 3943 I abi@e-tervis.ee

PERSONAL HEALTH STATEMENT

Health declaration (HD) is information submitted by the person regarding their medical state based on a corresponding questionnaire. HD is accessible to the patient's physicians or members of the medical committees of the Estonian Ministry of Defence, giving a quick overview of the patients health or condition and background information for making a more exact treatment or other health related decision. HD is usually filled out electronically in the patient portal, in exceptional cases on paper for objective reasons. HD is an obligatory prerequisite for obtaining health certificate or passing medical committee of Ministry of Defence. If the patient wants to answer only certain question which are mandatory in regards to the field of use of the HD, then the HD must be filled out on paper. All of the questions in the electronic HD are mandatory.

The patient verifies the HD with his or her signature and it is valid for 30 days in case of health certificate and 3 months in case of medical committees of the Ministry of Defence. HD filled out on paper is only valid for one doctors appointment and the next time the patient must fill out or insert all the information fields on the HD again. Additionally, HD filled out on paper (unlike electronically filled out HD in the patient portal) is not accessible later through the patient portal.

Personal identity code ☐☐☐☐☐☐☐☐☐☐☐ **Name** ______________________________

1. LIFESTYLE

Do you drink alcohol? ☐ No ☐ Yes

How many units of alcohol in a week?______ units (1 unit = 40 ml of spirits (40% alcohol by volume) or 120 ml of wine (12% alcohol) or 250 ml of beer (5,2% alcohol)

Do you smoke? ☐ No ☐ Yes

How many cigarettes a day? __________

How many years have you been smoking? ____

If you have quit smoking, when did you quit? ____

Do you use drugs / psychotropic substances? ☐ No ☐ Yes

Please, specify how often ____

Are you taking any medication that in your opinion could affect your coordination or concentration ability? ☐ No ☐ Yes

2. WORKING ENVIRONMENT

Have you had any work restrictions recommended by a physician or licenced health care professional?

☐ No ☐ Yes **If so, please specify** ____

____

Do you currently have or have had any health problems that are related to your work or working environment? ☐ No ☐ Yes ____

____

3. ALLERGIES

None ☐

☐ **Drug allergy (please specify)** ____

☐ **Food allergy (please specify)** ____

☐ **Pollen allergy (please specify)** ____

☐ **Domestic pets allergy (please specify)** ____

☐

Name____________________________ **Date**________________ **Signature**__________________________

Other allergies (please specify) ______

4. MENTAL HEALTH

No complaints ☐

- ☐ **Depression** ______
- ☐ **Schizophrenia** ______
- ☐ **Fear of working alone** ______
- ☐ **Fear of closed spaces** ______
- ☐ **Fear of heights** ______
- ☐ **Other disease / condition / symptom (please specify)** ______

5. NERVOUS SYSTEM

No complaints ☐

- ☐ **Fainting spells (syncope)** ______
- ☐ **Convulsions (epilepsy)** ______
- ☐ **Balance disorders (incl. Meniere's disease)** ______
- ☐ **Cerebral infarction or stroke** ______
- ☐ **Seasickness** ______
- ☐ **Other disease / condition / symptom (please specify)** ______

6. EYES AND VISION

No complaints ☐

- ☐ **Short-sightedness** ______
- ☐ **Visual field restriction when looking up and down or to the sides?** ______
- ☐ **Double vision** ______
- ☐ **Colour vision disorders** ______
- ☐ **Other disease / condition / symptom (please specify)** ______

7. EAR, NOSE, THROAT

No complaints ☐

- ☐ **Hearing loss** ______
- ☐ **Allergic rhinitis** ______
- ☐ **Chronic sinusitis of frontal or maxillary sinuses** ______
- ☐ **Nasal obstruction** ______
- ☐ **Frequent (more than 4x a year) throat problems** ______
- ☐ **Other disease / condition / symptom (please specify)** ______

Name______ **Date**______ **Signature**______

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8. RESPIRATORY SYSTEM

No complaints ☐

- ☐ Asthma ____
- ☐ Chronic obstructive pulmonary disease (COPD) ____
- ☐ Sleep apnoea ____
- ☐ Other disease / condition / symptom (please specify) ____

____

9. METABOLIC DISORDERS (INCL THYROID DISEASE)

No complaints ☐

- ☐ Diabetes ____
- ☐ Other disease / condition / symptom (please specify) ____

____

10. CARDIOVASCULAR CONDITION

No complaints ☐

- ☐ Chest pain related to physical activity ____
- ☐ High blood pressure ____
- ☐ I have had a heart attack ____
- ☐ Irregular heartbeat (arrhythmia) ____
- ☐ I have had coronary angioplasty (coronary stent procedure) ____
- ☐ I have a pacemaker ____
- ☐ I have had a heart surgery ____
- ☐ Other disease / condition / symptom (please specify) ____

____

11. BONES, JOINTS AND MUSCLES

No complaints ☐

- ☐ Joint stiffness ____
- ☐ Partial or complete paralysis of limb (please specify) ____
- ☐ Missing of a complete or part of a limb (please specify) ____
- ☐ Trembling hands ____
- ☐ Joint pain ____
- ☐ Neck pain ____
- ☐ Shoulder pain ____
- ☐ Lower back pain ____
- ☐ Other disease / condition / symptom (please specify) ____

____

Name____ **Date**____ **Signature**____

12. INFECTIOUS DISEASES

I have not had any to my knowledge ☐

☐ **Tuberculosis** ______

☐ **Viral hepatitis** ______

☐ **HIV carrier** ______

☐ **AIDS** ______

☐ **Other disease / condition / symptom (please specify)** ______

______

13. OTHER CHRONIC DISEASES, CONDITIONS OR SYMPTOMS NOT DESCRIBED ABOVE

None ☐

☐ **Disease / condition / symptom (please specify, when and what)** ______

______

14. TREATMENT UP TO NOW

☐ **Have you been hospitalized or visited a doctor abroad?** Please specify why, when and where

______

______

☐ **Are you taking regularly any medication (incl. contraceptives)? If so, please list**

______

______

☐ **Have you been hospitalized?** ______

______

☐ **Have you had surgery?** Please specify why and when ______

______

15. TRAUMAS

None ☐

☐ **Bone fractures (please specify, when and what)** ______

☐ **Other significant injuries (please specify, when and what)** ______

______

16. ARE YOU PREGNANT? ☐ No ☐ Yes

17. SKIN DISORDERS (PLEASE SPECIFY, WHEN AND WHAT) ☐ No ☐ Yes

______

Name______ **Date**______ **Signature**______

18. DIGESTIVE ORGANS

No complaints ☐

☐ Liver disease ______
☐ Gallstones ______
☐ Gastric and duodenal ulcers ______
☐ Ulcerative colitis or Crohn's disease ______
☐ Other disease / condition / symptom (please specify, when and what) ______

______

19. UROGENITAL SYSTEM

No complaints ☐

Kidney diseases ______
☐ Kidney stones ______
☐ Renal insufficiency ______
☐ Other disease / condition / symptom (please specify, when and what) ______

______

20. BLOOD PROBLEMS

No complaints ☐

Blood disease ______
☐ Anaemia (iron-deficiency) ______
☐ Other disease / condition / symptom (please specify, when and what) ______

______

21. I USE THE FOLLOWING MEDICAL DEVICES / SUPPORT DEVICES

None ☐

☐ Glasses ______
☐ Contact lenses ______
☐ Hearing aid / cochlear implant ______
☐ Arm prosthesis ______
☐ Leg prosthesis ______
☐ Mobility support device ______
☐ Continuous positive airway pressure (CPAP) device or non-invasive ventilation device ______

______

☐ Mandibular advancement splint for treatment of sleep apnoea ______
☐ Other support device (please specify, what) ______

22. SLEEP

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ☐ No ☐ Yes

Do you often feel tired, fatigued, or sleepy during daytime? ☐ No ☐ Yes

Has anyone observed you stop breathing during your sleep? ☐ No ☐ Yes

Name______ Date______ Signature______