PERSONAL HEALTH STATEMENT

Personal health statement is a written summary of an individual's medical condition based on a voluntarily completed questionnaire. The contents of a personal health statement is made available to a patient's physician providing a brief summary of a patient's medical condition as well as sharing supplementary information for adequate decision-making on medical care or other issues. By convention a personal health statement is completed online and submitted to the patient portal, whereas only in the case of extraordinary circumstances a paper form is used. Personal health statement is a mandatory prerequisite for acquiring an official health certificate.

Personal health statement is to be confirmed by the patient with a (digital) signature and will remain valid for a period of thirty (30) days. Personal health statement submitted on paper is valid for only once and is not reusable.

Likewise, the personal health statement submitted on paper (unlike the electronically submitted health statement) is not later accessible via the patient portal.

Personal identity code ☐☐☐☐☐☐☐☐☐☐☐ **Name**_____

1. LIFESTYLE

Do you drink alcohol? ☐ No ☐ Yes

How many units of alcohol in a week? _____ (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

Please describe your sleep habits

_____

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)**_____

☐ **Other allergies (please specify)** _____

_____

Name_____ **Date**_____ **Signature**_____

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) _____

8. RESPIRATORY SYSTEM

No complaints ☐

- ☐ Asthma _____
- ☐ Chronic obsturctive pulmonary disease (COPD) _____
- ☐ Other disease / condition / symptom (please specify) _____

_____

_____

Name _____ Date _____ Signature _____

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 (arrythmia) _____

☐ 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) _____

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 _____

_____

_____

Name _____ Date _____ Signature _____

☐ 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 _____

_____

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_____

- ☐ Anemia (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 _____

Other support device (please specify, what)_____

Name_____ Date_____ Signature_____