

Preliminary Information Form

Please fill in this preliminary information form before the first doctor's appointment at Docrates Cancer Center. This information is needed for examinations and treatment planning as well as for its implementation. Thank You for your co-operation.

Name	Last name	First name
Social security number		
Date of Birth (dd/mm/yyyy)		
Profession		

Do you smoke?	<input type="checkbox"/> never <input type="checkbox"/> not any longer, I quit in year _____ <input type="checkbox"/> yes, how many years _____	
Use of alcohol	<input type="checkbox"/> none <input type="checkbox"/> average _____ per week	
Cancer in the immediate family		
Relationship:	Cancer type:	Age at onset of the disease:
Medications in use (continue on the reverse side if needed)	Name and strength of medicine	Dose and starting year
Vitamins, minerals and natural remedies being used		
Allergies (especially drug allergies)		
Women:		
Age at end of menstruation:	Hormone replacement therapy:	
Childbirth (years):	<input type="checkbox"/> actual <input type="checkbox"/> in use during years: _____	

Height (cm)	Weight (kg)
--------------------	--------------------

Have you currently or have you in the past had any of the following diseases / disorder? (mark all, write year of illness and specify)

- malignant tumor, cancer _____
- hypertension, cardiovascular disease _____
- pacemaker _____
- type 1 diabetes _____
- type 2 diabetes _____
- thyroid gland disease _____
- thrombosis or pulmonary thromboembolism _____
- risk of bleeding _____
- lung disease _____
- urinary disease _____
- skin disease _____
- ear disease or hearing loss _____
- stomach or intestinal disease _____
- liver or pancreas disease _____
- kidney disease _____
- neurological disease _____
- recurring headache or migraine _____
- mental disorder or illness _____
- eye disease _____
- rheumatoid arthritis or other rheumatic disease _____
- musculoskeletal disease _____
- other disease _____
- I have had Covid-19, when: _____
- I have been vaccinated with Covid-19 vaccine; when: _____
- surgeries performed (year) _____
- foreign objects in the body (which can interfere with imaging, such as a hip prothesis) _____

Choose the correct answers for the following questions (mark with a cross (x) and specify)

- | No | Yes | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have occupational health care? If you answered Yes, where is your occupational health care provided? (The question is intended especially for persons living in Finland)
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have or have you contracted bloodborne diseases (HIV, hepatitis, MRSA)? Which? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an MRSA sample taken? Where and when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been treated in a public sector hospital in Finland or in a hospital abroad within 6 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you or have you been working in a hospital? Where and when? _____ |

Signature

Place and date: _____ / _____ / 20_____

Signature (for under 18 y.o. signs the parent)

Name