HEALTH AND WELFARE
INFORMATION SYSTEMS CENTRE

Support: 794 3943
abi@tehik.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)** ____________________

☐

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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) ____________________

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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**____________________

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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

____

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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____________________