T

DOCTOR'S STATEMENT

Purpose of the examination
☐ Post or position ☐ School or institute ☐ Life insurance ☐ Other personal insurance ☐ Retirement pension insurance ☐ Which Other

PERSONAL AND OTHER INFORMATION

Surname	First names	Identity number
Street address	Post code / City	Occupation
Identity: ☐ Personally known ☐ Identity card ☐ Not ascertained	The patient's opinion on his/her present health: ☐ Good ☐ Fair ☐ Bad	Uses medication often or regularly: ☐ Yes ☐ No
National service: ☐ Done ☐ Not done	Years of service	Fitness rating

INFORMATION ON PRESENT AND PREVIOUS ILLNESSES AND DISORDERS

01 Hospital care or examinations: ☐ In a hospital ☐ In a mental hospital ☐ In another institution			02 Operations: ☐ Yes ☐ No
03 Radiotherapy: ☐ Yes ☐ No	04 Cancer, leukemia or other malignant tumor: ☐ Yes ☐ No	05 Heart disease: ☐ Yes ☐ No	06 Hypertension or other vascular disease: ☐ Yes ☐ No
07 Lung disease: ☐ Yes ☐ No	08 Gastric ulcer or other gastrointestinal disease: ☐ Yes ☐ No	09 Cystitis or disease of the urinary system: ☐ Yes ☐ No	10 Gynecological disease or disorder during pregnancy: ☐ Yes ☐ No
11 Pregnancy: ☐ Yes ☐ No	Estimated date of delivery	12 Diabetes or other metabolic disturbance: ☐ Yes ☐ No	13 Eczema: ☐ Yes ☐ No
14 Allergy or hypersensitivity: ☐ Yes ☐ No	15 Disease in the back, the neck or the joints: ☐ Yes ☐ No	16 Paralysis, convulsion, unconsciousness or migraine: ☐ Yes ☐ No	17 Eye disease or injury: ☐ Yes ☐ No
18 Ear disease or deafness: ☐ Yes ☐ No	19 Psychic illness: ☐ Yes ☐ No	20 Abuse of alcohol or intoxicants: ☐ Yes ☐ No	21 Difficult accident or war injury, other difficult chronic or recurring illness: ☐ Yes ☐ No

Entry	Type of illness, starting time, treatment, hospital or doctor, recurrence of illness and other results	22 Other findings ☐ ☐
		☐ Cont. in appendix — Appendix number

DOCTOR'S KNOWLEDGE OF THE PATIENT

☐ I do not know the prior health of the patient	☐ I know the prior health of the patient	☐ I have followed the health of the patient	Personally since (Date)	From documents since (Year)

I heraby declare the above information to be correct.
Patient's signature

EXAMINATION RESULTS

Height cm	Weight kg	Pulse	Blood pressure mmHg	Sight without glasses: Right eye	Sight without glasses: Left eye	Sight with glasses: Right eye	Sight with glasses: Left eye
Colour vision: ☐ N ☐ A	Hearing m: Right ear / Left ear		01 Psychic health: ☐ N ☐ A	02 Nervous system: ☐ N ☐ A	03 Eyes: ☐ N ☐ A	04 Ears: ☐ N ☐ A	05 Mouth and throat: ☐ N ☐ A
06 Teeth: ☐ N ☐ A	07 Thyroid gland: ☐ N ☐ A	08 Heart and circulatory system: ☐ N ☐ A	09 Superficial veins: ☐ N ☐ A	10 Respiratory organs: ☐ N ☐ A	11 Abdominal region: ☐ N ☐ A	12 Skin: ☐ N ☐ A	13 Lymph glands: ☐ N ☐ A
14 Joints: ☐ N ☐ A	15 Back and neck: ☐ N ☐ A	16 Anomalies: ☐ N ☐ A	17 Scars: ☐ N ☐ A	18 Hernia: ☐ N ☐ A	19 Other findings ☐		

N = Normal, A = Abnormal

Entry	Additional explanations
	☐ Cont. in appendix — Appendix number

Results from laboratory tests and other special tests

Important observations not mentioned before

STATEMENT ON THE PATIENT'S SUITABILITY FOR THE GIVEN PURPOSE

☐ Suitable ☐ Suitable with restrictions *) ☐ Unsuitable *) ☐ No opinion *)

Special reasons
*)

Appendices

I heraby declare the above information to be correct and complete to the best of my knowledge
Date and place

Doctor's signature

Name (in block capitals), stamp

THE PATIENT

KOTKASET HAMINA 59001

Suomen Lääkäriliitto