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?	☐never ☐not any longer, I quit in year_____ ☐yes, how many years _____	
Use of alcohol	☐ none ☐ 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: Childbirth (years):	Hormone replacement therapy: ☐ actual ☐ 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
☐	☐ Do you have occupational health care? If you answered Yes, where is your occupational health care provided? (The question in intended especially for persons living in Finland) _____
☐	☐ Do you have or have you contracted bloodborne diseases (HIV, hepatitis, MRSA)? Which? _____
☐	☐ Have you hade an MRSA sample taken? Where and when? _____
☐	☐ Have you been treated in a hospital within 6 months? Where? _____
☐	☐ 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