We would appreciate it if you would fill in this form about your health. If your household consists of more than one person, please have a separate one for each person to fill in a form.

|  |  |
| --- | --- |
| Name |  |
| Date of birth |  |
| Identification | Passport Drives license, number: |
| Marital status | single / living together / married / divorced / widowed |
| Religion |  |
| Nationality |  |
| Study discline / profession |  |
| Profession | werkzaam/werkeloos/arbeidsongeschikt/gepensioneerd sinds: |
| Donor codicil | no / yes |
| Euthanasia passport | no / yes since: |
| I give my healthcare provider permission to share my data via the LSP | O Yes, I agree  O No, I do not give permission |

1. Do you have one or more of the following conditions and for how long?

O Diabetes

O Lung disease: asthma, COPD or other .......................................................

O High blood pressure

O High cholesterol

O Cardiovascular disease, namely .......................................................

O Psychiatric illness, namely .......................................................

O Ailments of the liver or intestines, namely .......................................................

O Chronic symptoms of the joints

O Sexually transmitted disease, namely .......................................................

O Kidney disease

O Thyroid problems

O Gestational diabetes

O Preeclampsia

O Other illness, namely .......................................................

1. Are you currently being treated by a specialist?

O No

O If yes, please fill in the table below

|  |  |  |
| --- | --- | --- |
| Name specialist | Which hospital | For what treatment |
|  |  |  |
|  |  |  |
|  |  |  |

1. Have you ever had an operation?

O No

O Yes, please list any operations in the following table

|  |  |
| --- | --- |
| Date of operation | Operation |
|  |  |
|  |  |
|  |  |

1. Do you currently take any medicine?

O No

O Yes, Please list the medicines in the following table

|  |  |  |
| --- | --- | --- |
| Medicine name | Strength | Dosage |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Are you hypersensitive (allergic)?

O No

O Yes, for medicine, namely ........................................................................

Specific food or drink, namely ….............................................................

Other, namely ........................................................................

1. Do you smoke?

O No

O Yes, ...... cigarettes/shag/cigar/pipe per day

O Stopped since: ………………….

1. Which illnesses are in the family and who suffers from them (father/mother/brother/sister /grandparent on mother’s side etc.)?

O Diabetes by whom: …………….…………………………………………………….

O High Blood Pressure by whom: …………….…………………………………………………….

O High cholesterol by whom: …………….…………………………………………………….

O Cardiovacsulair disease by whom: …………….…………………………………………………….

O Stroke or brain hemorrhage by whom: …………….…………………………………………………….

O Lung disease: asthma/COPD by whom: …………….…………………………………………………….

O Kidney disease by whom: …………….…………………………………………………….

O Psychiatric illness by whom: …………….…………………………………………………….

O Cancer + type of cancer by whom: …………….…………………………………………………….

1. Please mention here anything that you think that your doctor should be aware of:

.....................................................................................................................

.....................................................................................................................

.....................................................................................................................

.....................................................................................................................

.....................................................................................................................

.....................................................................................................................

#### Thank you for completing the questionnaire.