AkerCare

Healthy and safe solutions every day

Self-declaration Health

Surname:	First name:	Social security number:
Travel destination:	Email:	Mobile:

Have you been hospitalised during the last 2 years? If yes; when, why and where:	Yes ☐ No ☐
Have you been on sick leave for more than 4 weeks during this period?	Yes ☐ No ☐
Have you been on sick leave during the last 12 months?	Yes ☐ No ☐
Have you had on or more of the following diseases or conditions:	
Asthma, COPD, pneumonia, or other lung diseases	Yes ☐ No ☐
Chest pain, heart attack, irregular heartbeats or other heart problems	Yes ☐ No ☐
High blood pressure in need of medical treatment	Yes ☐ No ☐
Stroke, TIA, severe concussions or other brain trauma	Yes ☐ No ☐
Seizures, loss of consciousness or other neurological problems	Yes ☐ No ☐
Cancer of any type	Yes ☐ No ☐
Eczema, psoriasis or other skin diseases	Yes ☐ No ☐
Gastritis, ulcer, gallstone, liver problems or other stomach/bowl diseases	Yes ☐ No ☐
Kidney stone, kidney failure, infections in the urinary or reproductive tract	Yes ☐ No ☐
Hepatitis, malaria, tuberculosis, salmonella or other serious infectious diseases	Yes ☐ No ☐
Diabetes 1 or 2, thyroid problems or any other metabolic disease	Yes ☐ No ☐
Disc herniation, sciatic pain, spinal cord injury, fractures or other back problems	Yes ☐ No ☐
Osteoarthritis, rheumatoid arthritis, movement limitation or other joint/muscular/skeletal problems	Yes ☐ No ☐
Depression, anxiety, phobias, ADHD, psychosis or other serious psychological problems	Yes ☐ No ☐
Misuse of alcohol, narcotics, anabolic steroid or any chemical substance dependency	Yes ☐ No ☐
Reduced vision resulting in use of glasses, lenses or corrective surgery	Yes ☐ No ☐
Impaired hearing (by self-observation or audiometric testing)?	Yes ☐ No ☐
Other conditions or health problems not mentioned above If yes, please specify:	Yes ☐ No ☐
For women only:	
Are you pregnant or plan a pregnancy within the next 6 months?	Yes ☐ No ☐
Have you had a gynaecological exam within the last 2 years?	Yes ☐ No ☐

Date and place: Signature:

I declare the above information to be correct. I am aware that it is my duty to report any change of my health conditions as this may require a new health assessment and a renewal of the fitness report

© 2016 Aker Care