

## Questionnaire for statutory checkup Climbing with large height difference

If a statutory checkup BA Operations is to be conducted at the same time, no additional questionnaire is required.

Name	Social Security Number	Date
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### CARDIOVASCULAR RISK ASSESSMENT

#### Anamnesis

- Heredity.** Has a close relative been affected by...?
- |   | yes                      | no                       |
|---|--------------------------|--------------------------|
| Diabetes  | <input type="checkbox"/> | <input type="checkbox"/> |
| Hyperlipidemia  | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertension  | <input type="checkbox"/> | <input type="checkbox"/> |
| Myocardial infarction or Angina pectoris before the age of 60 | <input type="checkbox"/> | <input type="checkbox"/> |
| Sudden death  | <input type="checkbox"/> | <input type="checkbox"/> |
| Known other heart disease before the age of 60                | <input type="checkbox"/> | <input type="checkbox"/> |
| Marfan syndrome   | <input type="checkbox"/> | <input type="checkbox"/> |
| Other cardiovascular disease                                  | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above, describe here:

- Symptoms.** Have you felt...?
- |  | yes                      | no                       |
|--|--------------------------|--------------------------|
| Chest pain or chest discomfort with exertion?              | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe "abnormal" shortness of breath/fatigue on exertion? | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart palpitations or dysrhythmias during exertion?        | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting or feeling faint when exerting yourself?          | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness on exertion?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| That your fitness has deteriorated for an unknown reason?  | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above, describe here:

- Medical history.** Do you have or have you had...?
- |   | yes                      | no                       |
|---|--------------------------|--------------------------|
| High blood pressure at some point in your life?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Myocarditis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Pericarditis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Other heart or lung disease?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy-treated cancer?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Another illness or other thing that you think might be important? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above, describe here:

## HEALTH DECLARATION

Have you sought care due to illness or the equivalent as follows in the past year??

	yes	no
Occupational injury or accident	<input type="checkbox"/>	<input type="checkbox"/>
Other injury/accident	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort from the musculoskeletal system	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disease (paralysis, epilepsy, chronic pain)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss or other hearing/sense of balance problems	<input type="checkbox"/>	<input type="checkbox"/>
Vision impairment or other vision problems	<input type="checkbox"/>	<input type="checkbox"/>
Psychological problems (especially cell fear)	<input type="checkbox"/>	<input type="checkbox"/>
Skull injury/unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort associated with diving or flying	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/skin problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergic complaints	<input type="checkbox"/>	<input type="checkbox"/>

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	yes	no
Do you use glasses/lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been treated in hospital or sought a doctor in the past year? If yes, why?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been absent from work due to illness in the past year? If yes - how many days?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use medicine regularly? If yes - which medicines do you use, strength and dose?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel completely healthy?	<input type="checkbox"/>	<input type="checkbox"/>

### Exercise and movement

How much time do you spend in a typical week on physical exercise that makes you short of breath, such as running, gymnastics or ball sports??

- |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| No time at all           | 30 min                   | 60 min                   | 90 min                   | 120 min                  | 150 min or more          |

How much time do you spend in a typical week on everyday exercise, for example walking, biking or gardening?

- |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| No time at all           | 30 min                   | 60 min                   | 90 min                   | 120 min                  | 150 min or more          |
- 

### Eating habits

How often do you eat fruit and vegetables?

- |                              |                          |                          |                              |                          |
|------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|
| <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| 2 times/day<br>or more often | 1 time/day               | A few times/week         | Once a week<br>or less often | Never or<br>almost never |

Hur ofta äter du kaffebröd, choklad/godis, chips eller läsk/saft?

- |                              |                          |                          |                              |                          |
|------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|
| <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| 2 times/day<br>or more often | 1 time/day               | A few times/week         | Once a week<br>or less often | Never or<br>almost never |
- 

### Tobacco

Smoking habits

- |                               |  |                               |                                 |                                     |
|-------------------------------|--|-------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/>      | <input type="checkbox"/>                 | <input type="checkbox"/>      | <input type="checkbox"/>        | <input type="checkbox"/>            |
| I have never<br>been a smoker | I quit smoking less<br>than 6 months ago | I smoke 1-9<br>cigarettes/day | I smoke 10-19<br>cigarettes/day | I smoke $\geq$ 20<br>cigarettes/day |

Snuff habits

- |                                |   |                           |                           |                                |
|--------------------------------|---|---------------------------|---------------------------|--------------------------------|
| <input type="checkbox"/>       | <input type="checkbox"/>                        | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/>       |
| I have never<br>been a snuffer | I stopped using snuff<br>less than 6 months ago | I snuff 1-3<br>packs/week | I snuff 4-6<br>packs/week | I snuff $\geq$ 7<br>packs/week |

**Alcohol**

How often do you drink alcohol?

- Never                     
  1 time/month or more rarely                     
  2–4 times/month                     
  2–3 times/week                     
  4 times/week or more

How many “glasses” do you drink on a typical day when you drink alcohol?

- 1–2                     
  3–4                     
  5–6                     
  7–9                     
  10 or more

Examples of glass meant:



**Drugs**

yes                      no

Have you tried drugs?

- 

If YES, what, when and to what extent??