# Questionnaire before medical checkup

| First name | Social Security Number | Date |
|---|---|---|
| | | |

## Physical exercise

How often during a normal week do you do physical exercise that makes you breathless, for example running, keep-fit exercises or ball games?

☐ No time ☐ 30 minutes ☐ 60 minutes ☐ 90 minutes ☐ 120 minutes ☐ 150 minutes or more

How much time during a normal week do you get ordinary exercise in,for example, walking, cycling or gardening?

☐ No time ☐ 30 minutes ☐ 60 minutes ☐ 90 minutes ☐ 120 minutes ☐ 150 minutes or more

## Food & nutrition

How often do you eat fruit and vegetables?

☐ Twice a day or more ☐ Once a day ☐ A few times a week ☐ Once a week or less ☐ Never or almost never

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

☐ Twice a day or more ☐ Once a day ☐ A few times a week ☐ Once a week or less ☐ Never or almost never

## Tobacco

Smoking habits

☐ I have never smoked ☐ I stopped smoking more than 6 months ago ☐ I stopped smoking less than 6 months ago ☐ I smoke 1–9 cigarettes per day ☐ I smoke 10–19 cigarettes per day ☐ I smoke more than 20 cigarettes per day

Moist snuff habits

☐ I have never used moist snuff ☐ I stopped using moist snuff more than 6 months ago ☐ I stopped using moist snuff less than 6 months ago ☐ I use 1–3 cans of moist snuff per week ☐ I use 4–6 cans of moist snuff per week ☐ I use more than 7 cans of moist snuff per week

## Alcohol

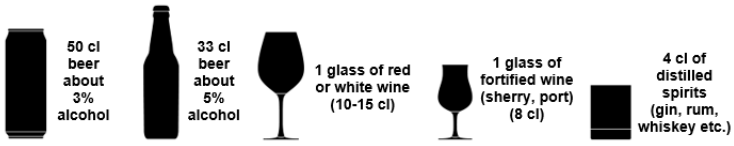
How often do you drink alcohol?

☐ 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

Have you tried drugs? ☐ Yes ☐ No

If yes, what, when and to what extent?

_____

_____

_____

## Background

Have any of your parents or siblings suffered from a heart attack?
or cerebral haemorrhage/clot in the brain before the age of 65? ☐ Yes ☐ No

Have you ever been informed that your blood pressure is elevated? ☐ Yes ☐ No

Do you use any medication? ☐ Yes ☐ No

If yes, state which one/ones:

_____

## Symtoms

Have you previously had any serious illness? ☐ Yes ☐ No

If yes, state which one/ones: _____

| | Contin-uously | A large part of the time | Some of the time | A small part of the time | Not at all |
|---|---|---|---|---|---|
| Do you sleep restlessly or do you have difficulty falling asleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you often feel tired? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you often feel restless and/or tense? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you often feel down, moody or sad? | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Very bad | | | | Excellent |
|---|---|---|---|---|---|
| How do you feel about your general state of health? | ☐ | ☐ | ☐ | ☐ | ☐ |