Initial health examination for school-age children and adolescents seeking asylum

Kouluikäisten turvapaikkaa hakevien lasten ja nuorten alkuterveystarkastus [Englanti]

PRELIMINARY INFORMATION (MEDICAL HISTORY)				
Background information	**FAMILY NAME AND GIVEN NAMES:**	**DATE OF BIRTH**	**UMAREK-NUMBER:**	**COUNTRY OF BIRTH:** In what country were you born? *Enter country of birth / Unknown*
	FAMILY: Who are the members of your family and who do you live with? Have there been any changes to the family structure?		**FAMILY STRESSORS:** Are there currently any stressful things in your family life such as loss/bereavement, hardship, or adversities?	
	LITERACY: What is your level of reading? *I can read a wide range of texts / I can read simple texts / I can read names, words, and very simple sentences / I cannot read.*			**YEARS OF SCHOOL ATTENDANCE:** How many years have you gone to school?
	PLACES OF RESIDENCE: In which countries have you lived before coming to Finland? *Enter countries of residence / No countries of residence / Unknown*		**CIRCUMSTANCES:** Have you lived on the street, in a refugee camp, in a reception centre, a detention centre, or prison? *No / On the street / In a refugee camp / In a reception centre / In a detention centre / In prison / Unknown*	

Develop	Have you grown and developed similarly to other children of your age? *Yes / No / Unknown*

Diseases	**PERCEIVED HEALTH:** How would you describe your current state of health? *Response options: Very good / Good / Satisfactory / Poor / Very poor*	**DISEASES**: Do you have a long-term illness or health problem? These include conditions such as hypertension, depression, heart disease, or allergies. *Enter health condition(s) / None / Unknown*
	TUBERCULOSIS HISTORY: Have either yourself, a member of your immediate family, or a relative previously been diagnosed with tuberculosis? *Yes / No / Unknown*	**PERIODS OF HOSPITAL CARE AND SURGICAL PROCEDURES**: Have you had any significant periods of hospital care, surgical procedures, medical investigations, or treatments? *Yes / No / Unknown*

Medication	**CURRENT MEDICATION:** What medication(s) are you currently taking? Have you been prescribed any medication(s) that you are not currently taking?

Current state of health	**SYMPTOMS:** Have you had any symptoms or problems in the last month? Symptoms may include, for example, toothache, headache or back pain, stomach pains, skin irritation, or unintentional weight loss. *Yes / No / Unknown*	
	FEVER: Have you had a fever that lasted for more than three weeks? *Yes / No / Unknown*	**COUGHING**: Have you coughed up blood or mucus during the last month? *Yes / No / Unknown*
	FUNCTIONAL CAPACITY: Are you limited from participating in common daily activities by a health problem? Response options*: Not restricted / Restricted, but not seriously / Seriously restricted.*	
	VISION: Do you have a problem with your vision that affects your ability to carry out everyday activities? *Yes / No / Unknown*	**HEARING:** Do you have a problem with your hearing that affects your ability to carry out everyday activities? *Yes / No / Unknown*

Mental welfare	**TRAUMATIC EXPERIENCES:** Some people experience things that can be extremely upsetting and which can even have a long-term impact on their health and wellbeing. I'm now going to ask you about a few of these kinds of experiences. Has the child or young adult experienced an emotionally or physically traumatic event or incident? These kinds of events may be, for example, being involved in an accident, being present during violent situations or conflicts, or becoming separated from a guardian. *Yes / No / Unknown*
	INJURIES: Have you / Has the child been injured as the result of an accident or an act of violence? *Yes / No / Unknown*
	EMOTIONAL LIFE: Do you/ Does the child have any difficulties in your / his or her emotional life? Issues with our emotional life can include irritability, sadness, anxiety, withdrawal, fear or thoughts that we would be better being dead. Response options: *Not at all / Less than once a year / Every year / Monthly or weekly / Daily / Unknown*
	CONDUCT DISORDER: Do you / Does the child have any behavioural problems? How often? Behavioural problems may include aggressive or indifferent behaviour and oppositional defiance (abnormally defiant for their developmental stage). Response options: *Not at all / Less than once a year / Every year / Monthly or weekly / Daily / Unknown*
	HYPERACTIVITY: Are you / Is the child hyperactive or have any difficulties concentrating? How often? Examples of these kinds of issues include an inability to concentrate, hyperactivity, and impulsivity. Response options: *Not at all / Less than once a year / Every year / Monthly or weekly / Daily / Unknown*

Health habits	**TOBACCO PRODUCTS:** Do you smoke cigarettes or use other nicotine such as e-cigarettes or Shisha OR have you previously smoked? *Tobacco / Snuff / E-Cigarette / Other*	**USE OF TOBACCO PRODUCTS:** How often? *Daily / Occasionally / Never / Quit*
	ADOLESCENT ALCOHOL USE: Do you consume alcohol? How often? Response options: *Daily / 3–6 times a week / 1–2 times / 1–3 times a month / 7–11 times a year / 4–6 times a year / 1–3 times a year / Less than once a year / Not at all*	
	USE OF OTHER SUBSTANCES: Have you used other drugs such as cannabis, khat or other drugs or medicines for the purpose of intoxication? *No / Opioids / Stimulants / Sleeping pills or sedatives / Hallucinogens / Solvents / Gamma (GBL) or lacquer / Cannabis / Other / Unknown*	
	DIET: Do you avoid some foods in your diet? *Lactose-free or low-lactose / Gluten-free / Vegetarian diet with dairy products and / or eggs / Vegetarian diet with fish / Vegan / Wheat allergy / Milk allergy / Other food allergy / Other special diet*	
	SLEEPING ISSUES: Have you had any sleeping issues in the last month, such as difficulty falling asleep or waking up several times per night? *Difficulty falling asleep / Difficulty staying asleep / Waking up too early in the morning / Disrupted circadian rhythm / Daytime tiredness / Other sleep disorder*	**DENTAL HYGIENE:** How often do you brush your teeth? Response options: *Twice a day or more often / Once a day / Less than once a day*

Sexual and reproductive health	**MENSTRUATION ONSET:** Have you started your period? *Yes / No / Unknown*		**MENSTRUAL PROBLEMS:** Do you have any problems with your periods / menstrual cycle? *No problem / Unusual period pain / Heavy bleeding / Irregular periods / Other problems, what?*	
	POSSIBLE PREGNANCY: Are you pregnant? *Yes / No / Unknown*	**LAST PERIOD:** When did you have your last period?	**NUMBER OF PREGNANCIES:** Have you ever been pregnant? If you have, how many times?	**NUMBER OF BIRTHS:** Have you given birth? If you have, how many times?
	I am now going to ask you some questions about your sexual partners. This helps us to understand if you are in need of information, testing, or treatment in relation to your sexual activity. When answering these questions it is really important that you think about your own individual situation and not what would be considered to be generally acceptable in your community or culture. Discrimination against anyone on the basis of their sexuality or sexual behaviour is not allowed in Finland.			

	SEXUAL INTERCOURSE: Have you ever had sex / sexual intercourse?		**SEX:** Have you had sex during the last year? *No sex at all / Heterosexual sex / Homosexual sex / I do not wish to say*
	NUMBER OF SEXUAL PARTNERS: With how many people have you had sex in the last year? *Only one / 1-10 / more than 10 / I do not wish to say*		**CONTRACEPTION:** Do you need contraception to prevent pregnancy or the spread of sexually transmitted infections? *I don't need and don't use / I need but I am not using / I use contraception / I do not wish to say*
	CIRCUMCISION: In some countries, girls/ boys may be circumcised, and this might have impact on the person's health. Have you been circumcised? *Yes / No / Unknown*	**PARENTAL CIRCUMCISION (DIRECT QUESTION AT PARENT):** Has the mother/father of the child been circumcised? *Yes / No / Unknown*	**CIRCUMCISION PLANS (DIRECT QUESTION AT PARENT):** Have you considered having your child circumcised? *Yes / No / Unknown*
	OTHER PRELIMINARY INFORMATION		

RISK INFORMATION (e.g. drug allergies)

CURRENT STATUS		
SKIN: Are there any skin abnormalities upon examination? *Yes / No / Unknown.*	**ORAL EXAMINATION:** Are there any abnormalities upon oral examination? *Yes / No / Unknown*	Other notes regarding current status

PHYSIOLOGICAL MEASUREMENTS		
BLOOD PRESSURE AND PULSE:		**BODY TEMPERATURE:**
WEIGHT (KG): Have there been any weight changes?	**HEIGHT (CM):**	**BMI:**

VACCINATIONS
PREVIOUS VACCINATIONS: Which vaccinations have you/your child had before arriving in Finland? *No vaccinations / Some vaccinations / All vaccinations provided in the country of origin*
VACCINATIONS HISTORY:

PLAN
PLAN:

FURTHER TREATMENT AND ADDITIONAL TESTING: *Chest X-Ray / Blood screening / Primary medical examination / Reception centre nurse / Doctor / Dentist / Family clinic / School or student health care / Social worker / Other referral or appointment*	
PATHWAY: *Health services / Non-prescription medication / Mental Health / Sexual and reproductive health / Nutrition / Oral health / Other pathway*	
CONSENT TO INFORMATION SHARING *Consent given / Conditional consent / Consent not given*	**CONSENT TO DATA RETRIEVAL** *Consent given / Conditional consent / Consent not given*
SIGNATURE	