Initial health examination for adults seeking asylum

Aikuisten turvapaikanhakijoiden alkuterveystarkastus [Englanti]

PRELIMINARY INFORMATION (MEDICAL HISTORY)			
	FAMILY NAME AND GIVEN NAMES:	**DATE OF BIRTH:**	**UMAREK-NUMBER:**

Background information		
	COUNTRY OF BIRTH: In what country were you born? *Enter country of birth / Unknown*	**LEVEL OF EDUCATION:** What is the highest level of education or qualification you have completed? *No education at all OR early childhood education / lower primary school / upper primary school / middle school / upper secondary school tertiary education / bachelor's degree / postgraduate research degree / educational level unknown*
	PROFESSION AND WORK: What was the nature of the work you primarily did before coming to Finland? *Military / Manager / Senior Specialist / Specialist / Clerical support workers / Service and sales worker / Skilled agricultural, forestry, and fishery workers. / Craft and related trades workers / Plant and machine operators, and assemblers / Elementary worker / Unknown*	**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.*
	NUMERACY: 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*

Diseases		
	PERCEIVED HEALTH: How would you describe your current state of health? Response options: *Very good / Good / Satisfactory / Poor / Very poor*	**CHRONIC ILLNESSES**: Do you have a chronic 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: *No 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. Have you experienced any of the following upsetting things? Have you been subjected to torture? Have you been subjected to sexual violence? Having been forced, pressured, or coerced/tricked into doing things you didn't want to do? Have you had other upsetting / traumatic experiences? What kind(s)? *No / Torture / Sexual violence / Coercion / Other traumatic experience / Unknown*	
	INJURIES: Have you been injured as the result of an accident or an act of violence? *Yes / No / Unknown*	**THREAT OF VIOLENCE**: Do you currently feel you are under threat of violence? *Yes / No / Unknown*
	MENTAL HEALTH SYMPTOMS (PROTECT SURVEY): I am now going to ask you about some of the symptoms that can be caused by the kinds of experiences I mentioned previously. Have you experienced any of the following during the last couple of weeks: [ ] problem falling asleep [ ] nightmares [ ] headaches [ ] other physical pain(s) [ ] irritability [ ] upsetting thoughts / memories [ ] fearfulness [ ] forgetfulness [ ] lack of interest [ ] difficulties concentrating Protect score: ____/ 10	
	SELF-HARM: Have you thought about harming yourself during the last couple of weeks? *Yes / No / Unknown*	

Health habits	**TOBACCO PRODUCTS:** Do you smoke cigarettes or use other products containing 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*
	ALCOHOL USE: Do you consume alcohol? *Yes / No / Unknown*		
	AUDIT-C SCREENING: 1. How often do you consume beer, wine or other alcoholic beverages? Also include the times when you only have a small amount, e.g. a bottle of medium-strength beer or a sip of wine? [ ] Never (0) [ ] Approx. once a month or less (1) [ ] 2-4 times a month (2) [ ] 2-3 times a week (3) [ ] 4 or more times a week (4)	2. How many drinks containing alcohol do you have on a typical day when you are drinking? [ ] 1-2 servings(0) [ ] 3-4 servings(1) [ ] 5-6 servings(2) [ ] 7-9 servings(3) [..] 10 or more (4)	3. How often have you had six or more drinks on one occasion? [ ] Never (0) [ ] Less than once a month (1) [ ] Once a month (2) [ ] Once a week (3) [ ] Daily or almost daily (4) Score: ____/ 16
	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*		

Sexual and reproductive health	**MENSTRUAL PROBLEMS:** Do you have any problems with your period / menstrual cycle? *No problem / Unusual pain while menstruating / Heavy menstrual bleeding / Irregular menstrual cycle / Other problems, what?*			
	PREGNANCY: Are you pregnant? *Yes / No / Unknown*	**YOUR LAST (MENSTRUAL) PERIOD:** When did you have your last (menstrual) 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.			

	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*	

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 in my 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	