

Arctic Medical Questionnaire and Examination
In land expeditions/flight missions
(Pilots, diving or marine personal not included)

To all expedition participants

General information

The detailed investigation into the medical history is intended to give the examining physician an overall picture of the state of health of the expedition participant that is as comprehensive as possible.

The exact knowledge of any previous illness not only serves to ascertain the actual medical prerequisites for participation in the expedition but in particular also to avoid possible health risks during the expedition.

Further information of past medical history may be of invaluable help in case of any need for medical treatment during the expedition or during evacuations.

The medical examination includes a physical examination, chest x-ray, blood tests, cardiac stress test and pulmonary function test. Further examinations may be needed depending on the individual state of fitness. Additional information from your general practitioner or other doctor who has been involved in your medical care might be needed.

Further the examination documents should include a confirmation issued by your dentist stating that your teeth have received adequate treatment.

Information on this form once completed is confidential.

The information will be placed sealed on the expedition base and will be returned to you at the end of the season. Only if needed for medical reasons the information will be disclosed.

When the medical history form has been completed please sign **on page**

Denmark
Arctic Medical Questionnaire and Examination
In land expeditions/flight missions
(Pilots, diving or marine personal not included)

Last name, First names _____

Date of birth _____ Age _____

Profession _____

Expedition Area _____

Period of stay _____

Type of work/activity _____

Home address _____

Telephone (home) _____

Telephone (work) _____

Mail _____

Doctors Final Comment

No Reservations in terms of health as regards the planned expedition

Reservations in terms of health

Participation in arctic expeditions is not recommendable

Date _____ Signature _____ Place _____

Medical History Questionnaire

Name : _____ **date** _____

Do you suffer or have you in the past suffered from the beneath mentioned diseases?

All questions MUST be answered

All questions answered with yes MUST be commented including explanations, the influence on actual health, dates and if possible diagnosis and received treatment or diagnostic procedures..

Heart/Cardiovascular

- | | | | | |
|---|-----|----|----|----|
| 1.1. High blood pressure | Yes | __ | No | __ |
| 1.2. Chest pain / Angina | Yes | __ | No | __ |
| 1.3. Heart Attack /Palpitations | Yes | __ | No | __ |
| 1.4. Former coronary artery angiography | Yes | __ | No | __ |
| 1.5. Ankle Swelling | Yes | __ | No | __ |
| 1.6. Varicose Veins | Yes | __ | No | __ |
| 1.7. Thrombosis of veins | Yes | __ | No | __ |
| 1.8. Any surgery in vessels | Yes | __ | No | __ |
| 1.9. Heart surgery | Yes | __ | No | __ |
| 1.10 Any cardiovascular disease | Yes | __ | No | __ |

Comment on all positive answers

Diseases of the lung / Respiratory

- | | | | | |
|-----------------------------------|-----|----|----|----|
| 2.1. Asthma or chronic bronchitis | Yes | __ | No | __ |
| 2.2. Former pulmonary embolism | Yes | __ | No | __ |
| 2.3. Shortness of breath | Yes | __ | No | __ |
| 2.4. Emphysema | Yes | __ | No | __ |
| 2.5. Persistent cough | Yes | __ | No | __ |
| 2.6. Sarcoidosis | Yes | __ | No | __ |
| 2.7. Collapsed lung/Pneumothorax | Yes | __ | No | __ |
| 2.8. Tuberculosis | Yes | __ | No | __ |
| 2.9. Pneumonia | Yes | __ | No | __ |
| 2.10 Any lung diseases | Yes | __ | No | __ |

Medical History Questionnaire

Name : _____

date _____

Diseases of the Abdomen/Digestive organs

- 3.1. Stomach or duodenal ulcer Yes ___ No ___
- 3.2. Gall stones Yes ___ No ___
- 3.3. Diseases of the liver Yes ___ No ___
- 3.4. Diseases of the pancreas (*Bugspykirtel*) Yes ___ No ___
- 3.5. Appendicitis (*blindtarms betændelse*) Yes ___ No ___
- 3.6. Hernias (*Brok*) Yes ___ No ___
- 3.7. Abdominal pain Yes ___ No ___
- 3.8. Bleeding (vomiting or from anus) Yes ___ No ___
- 3.9. Any Abdominal disease Yes ___ No ___
- 3.10 Any Abdominal surgery Yes ___ No ___

Comment on all positive answers

Diseases of the Kidney or bladder

- 4.1. Renal diseases Yes ___ No ___
- 4.2. Kidney stones Yes ___ No ___
- 4.3. Kidney infections Yes ___ No ___
- 4.4. Abnormalities in kidney Yes ___ No ___
- 4.5. Blood in urine Yes ___ No ___
- 4.6. Difficulties passing urine Yes ___ No ___
- 4.7. Cystitis/Infection in bladder Yes ___ No ___
- 4.8. Surgery in kidney Yes ___ No ___
- 4.9. Surgery in bladder Yes ___ No ___
- 4.10 Surgery in urinary tract Yes ___ No ___

Medical History Questionnaire

Name : _____

date _____

Only Women

- | | | | | |
|--------------------------------|-----|----|----|----|
| 5.1. Ectopic pregnancy | Yes | __ | No | __ |
| 5.2. Diseases of the breasts | Yes | __ | No | __ |
| 5.3. Ovary diseases | Yes | __ | No | __ |
| 5.4. Severe menstrual bleeding | Yes | __ | No | __ |
| 5.5. Gynaecological diseases | Yes | __ | No | __ |

Only Men

- | | | | | |
|--|-----|----|----|----|
| 5.6. Twisted testicles | Yes | __ | No | __ |
| 5.7. Prostatitis | Yes | __ | No | __ |
| 5.8. Epididymitis (<i>bitestikler</i>) | Yes | __ | No | __ |
| 5.9. Infections of genitals | Yes | __ | No | __ |
| 5.10. Any genital disease | Yes | __ | No | __ |

Diseases of joint, bones and muscles

- | | | | | |
|----------------------------|-----|----|----|----|
| 6.1. Broken bones | Yes | __ | No | __ |
| 6.2. Joint injuries | Yes | __ | No | __ |
| 6.3. Diseases of Back | Yes | __ | No | __ |
| 6.4. Diseases of the discs | Yes | __ | No | __ |
| 6.5. Arthritis | Yes | __ | No | __ |
| 6.6. Lumbago | Yes | __ | No | __ |
| 6.7. Muscle diseases | Yes | __ | No | __ |
| 6.8. Surgery in the back | Yes | __ | No | __ |
| 6.9. Surgery in bones | Yes | __ | No | __ |
| 6.10. Surgery of muscles | Yes | __ | No | __ |

Comment on all positive answers

Medical History Questionnaire

Name : _____

date _____

Diseases of Brain and Nerves/Neurological

- | | | | | |
|----------------------------------|-----|----|----|----|
| 7.1. Stroke | Yes | __ | No | __ |
| 7.2. Epilepsia | Yes | __ | No | __ |
| 7.3. Migraine | Yes | __ | No | __ |
| 7.4. Attacks of dizziness | Yes | __ | No | __ |
| 7.5. Any neurological disease | Yes | __ | No | __ |
| 7.6. Depression | Yes | __ | No | __ |
| 7.7. Panic or anxiety attacks | Yes | __ | No | __ |
| 7.8. Mental illness of any kind | Yes | __ | No | __ |
| 7.9. Abuse of alcohol or drugs | Yes | __ | No | __ |
| 7.10. Surgery of brain or nerves | Yes | __ | No | __ |

Comment on all positive answers

Diseases of Eyes, Ear, Nose and Throat

- | | | | | |
|-------------------------------------|-----|----|----|----|
| 8.1. Deafness | Yes | __ | No | __ |
| 8.2. Any diseases of the eyes | Yes | __ | No | __ |
| 8.3. Any diseases of the ear | Yes | __ | No | __ |
| 8.4. Sinuitis (<i>bihuler</i>) | Yes | __ | No | __ |
| 8.5. Tonsillitis (<i>Mandler</i>) | Yes | __ | No | __ |
| 8.6. Poor sight | Yes | __ | No | __ |
| 8.7. Constant use of glasses | Yes | __ | No | __ |
| 8.8. Recurrent bleeding of the nose | Yes | __ | No | __ |
| 8.9. Surgery of eyes, ear or nose | Yes | __ | No | __ |
| 8.10. Surgery of throat | Yes | __ | No | __ |

Medical History Questionnaire

Name : _____

date _____

Infectious diseases/Allergic diseases

- | | | | | |
|-----------------------------------|-----|----|----|----|
| 9.1. Hepatitis | Yes | __ | No | __ |
| 9.2. Malaria | Yes | __ | No | __ |
| 9.3. Tuberculosis | Yes | __ | No | __ |
| 9.4. Skin infections | Yes | __ | No | __ |
| 9.5. Rheumatic fever | Yes | __ | No | __ |
| 9.6. Allergy to Bites or food | Yes | __ | No | __ |
| 9.7. Allergy to food | Yes | __ | No | __ |
| 9.8. Anaphylaxis (<i>shock</i>) | Yes | __ | No | __ |
| 9.9. Any allergy | Yes | __ | No | __ |
| 9.10 Any Immunological disorder | Yes | __ | No | __ |

Comment on all positive answers

Endocrine Disorders/ Cancer diseases

- | | | | | |
|--|-----|----|----|----|
| 10.1. Diabetes | Yes | __ | No | __ |
| 10.2. Thyroid diseases (<i>stofskifte</i>) | Yes | __ | No | __ |
| 10.3 Gout (<i>struma</i>) | Yes | __ | No | __ |
| 10.4 Lipid disorders | Yes | __ | No | __ |
| 10.5 Any hormone disorder | Yes | __ | No | __ |
| 10.6 Any cancers | Yes | __ | No | __ |
| 10.7 Leukaemia | Yes | __ | No | __ |
| 10.8 Hodgkin disease | Yes | __ | No | __ |
| 10.9 Skin cancers | Yes | __ | No | __ |
| 10.10 Any Tumour disease | Yes | __ | No | __ |

Former expeditions

Have you ever had health troubles during participation in former expeditions?
If so state which

Medical History Questionnaire

Name : _____ **date** _____

Current state of Health

A. Are you allergic to any kind of Medicine?
If so state which

Comment on all positive answers

B. Are you currently under medical treatment?
If so state which

Comment on all positive answers

C. Are you currently taking regular medicine?
If so state which and dosage

Comment on all positive answers

D. Are you suffering from any chronic diseases?
If so state which

Comment on all positive answers

E. Have you received in-hospital treatment?
for the past 2 years?
If so state which

Comment on all positive answers

Medical History Questionnaire

Name : _____ **date** _____

F. Have you consulted a doctor for the past 2 years?
If so state why

Comment on all positive answers

G. Have you any other complaint, illness, injury
Or condition not previously mentioned?
If so state which

Comment on all positive answers

H. Have you ever undergone surgery?
If so state why and when

Comment on all positive answers

I. Have you ever been rejected for any employment?
Or from obtaining insurances on medical
Grounds – if so state why

Comment on all positive answers

J. Are you smoking? _____

K. Are you dinking alcohol on a daily basis _____

Medical History Questionnaire

Name : _____ **date** _____

Vaccinations

- When where you last vaccinated against Tetanus? date _____
- When where you last vaccinated against Hepatitis A or B? date _____
- When where you last vaccinated against diphtheria? date _____
- When where you last vaccinated against polio? date _____

My declaration

- I declare that the given information relating to my medical examination is true to my best belief.
- I am aware that any false statements or any failure to disclose diseases which result in emergency medical measures or evacuation during an expedition may put my health at risk and jeopardise safe and progress of the expedition.
- I understand that the decision on my fitness will be communicated to the leadership of the expedition.
- I accept that these information may be disclosed to the medical personal attached to the expedition or to the leadership of the expedition if required on medical grounds

Signed : _____ **date** _____

DOCTORS PAPERS

Name of the person examined _____

Date of Birth _____

Date of the examination _____

The data and examination should be within 4 months before departure.

The examination includes

- A. Laboratory tests (fasting) (to be attached to the file)
- B. X-ray of the chest at least within the last 5 years.
- C. Lung function test
- D. Twelve lead ECG trace
- E. Declaration from dentist
- F. Cardiac exercise test if age > 40 years
- G. A physical examination

Laboratory tests

Blood counts

Haemoglobin
Leukocytes + diff
Thrombocytes
Reticulocytes
Blood type

Plasma/serum analysis

Blood sugar
Creatinine
Uric acid
Sodium
Potassium
Calcium-ion
TSH
Total-Cholesterol
CRP
Bilirubin
AST
Alkaline phosphate
HBc, HBC antibody + HAV
Interferon-gamma TB test (born after 1973)
Factor 2-7-10 + APTT

Comment on all positive answers

Completed

Name : _____ date _____

Urinary tests

U-protein
U-blood
U-leukocytes

Comment on all positive answers

Completed

ECG

X-ray of the chest

Once every 5 years. Last X-ray date _____

Comment on all positive answers

Completed

Lung function test

Dentist declaration

Comment on all positive answers

Received

Cardiac Exercise test

Age > 40 years

Comment on all positive answers

Completed

Physical Examination

Name : _____ date _____

Female <input type="checkbox"/>		Male <input type="checkbox"/>
Height _____ m	Weight _____ kg	BMI _____ kg/m ² BT _____/_____

<u>Caput/facies</u>
Ears Eyes Cavum oris /teeth/ dentures

<u>Comment on all abnormalities</u>
Normal <input type="checkbox"/>

<u>Collum</u>
Lymph nodes Gl.Thyroidea Collum/mobility

<u>Comment on all abnormalities</u>
Normal <input type="checkbox"/>

<u>Skin</u>

<u>Comment on all abnormalities</u>
Normal <input type="checkbox"/>

<u>Pulmones</u>
St.p

<u>Comment on all abnormalities</u>
Normal <input type="checkbox"/>

<u>Cor</u>
St.c. / Signs of incompensation

<u>Comment on all abnormalities</u>
Normal <input type="checkbox"/>

Physical Examination

Name : _____ date _____

Collumna

Signs/mobility

Comment on all abnormalities

Normal

Abdomen

All Scars must be stated

Comment on all abnormalities

Normal

Extremities

Deformities, Articular swelling, Mobility

Comment on all abnormalities

Normal

Reflexes/Sensitivity

Biceps/Triceps
Patellar
Coordination
Romberg's test

Comment on all abnormalities

Normal

Physical Examination

Name : _____ date _____

Overall comments

[Empty box for overall comments]

Signed _____ Date _____

Name in capital letters/Stamp _____