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 artic 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 __

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 __

Comment on all positive answers

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 (*Bugspytkirtel*) 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 __

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 __

Comment on all positive answers

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 (*bitestikler* 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 __

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 (*bihuler)*	Yes __ No __
8.5	Tonsillitis (*Mandler)*	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 __

Comment on all positive answers

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 *(shock* Yes __ No __
9.9 Any allergy Yes __ No __
9.10 Any Immunological disorder Yes __ No __

Endocrine Disorders/ Cancer diseases

10.1. Diabetes Yes __ No __
10.2. Thyroid diseases *(stofskifte)* Yes __ No __
10.3 Gout *(struma)* 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 __
10.10Any Tumour disease Yes __ No __

Former expeditions

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

Comment on all positive answers

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 __________

Lung function test

Comment on all positive answers

Completed ☐

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 ☐	**Male** ☐
Height ________m Weight _________ kg BMI _______ kg/m^2 BT _______/________	

Caput/facies	**Comment on all abnormalities**
Ears **Eyes** **Cavum oris /teeth/ dentures**	**Normal** ☐

Collum	**Comment on all abnormalities**
Lymph nodes **Gl.Thyroidea** **Collum/mobility**	**Normal** ☐

Skin	**Comment on all abnormalities**
	Normal ☐

Pulmones	**Comment on all abnormalities**
St.p	**Normal** ☐

Cor	**Comment on all abnormalities**
St.c. / Signs of incompensation	**Normal** ☐

Physical Examination

Name : ____**date**______________

Collumna	Comment on all abnormalities
Signs/mobility	**Normal** ☐

Abdomen	Comment on all abnormalities
All Scars must be stated	**Normal** ☐

Extremities	Comment on all abnormalities
Deformities, Articular swelling, Mobility	**Normal** ☐

Reflexes/Sensitivity	Comment on all abnormalities
Biceps/Triceps Patellar Coordination Romberg's test	**Normal** ☐

Physical Examination

Name : ____date________________

Overall comments

Signed ____ Date________________________

Name in capital letters/Stamp____