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 (only if requested by the doctor), blood tests, cardiac stress test and pulmonary function test.
Further examinations may be needed depending on the individual state of fitness.
Also 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.
Only if needed for medical reasons the information will be disclosed.

Please answer all questions and sign on each page (name and date) before going to the doctors office.

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 __
10.10	Any 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 were you last vaccinated against Tetanus? - date:_____
- When were you vaccinated against covid-19 and which vaccine? - dates: _____

☐Pfizer-BioNTech ☐Moderna ☐Johnson&Johnson ☐AstraZeneca ☐Other: _____

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 6 months before departure.

The examination includes

A. Laboratory tests (fasting) (to be attached to the file)
B. X-ray of the chest (only if requested by the doctor).
C. Lung function test
D. Twelve lead ECG trace
E. Declaration from dentist
F. Cardiac exercise test (every second year) if age > 40 years (or if requested by the doctor).
G. A physical examination

Laboratory tests

Blood counts
Haemoglobin
Leukocytes + diff
Thrombocytes

Plasma/serum analysis
HbA1c
Creatinine
Uric acid
TSH
Total-Cholesterol
CRP
Bilirubin
ALAT

Comment on all positive answer

Completed ☐

Name : _____ **date** _____

Urinary tests	**Comment on all positive answers**
U-protein U-blood U-leukocytes	**Completed** ☐

ECG	**Comment on all positive answers**
X-ray of the chest Only if requested by the doctor.	
Lung function test	**Completed** ☐

Dentist declaration	**Comment on all positive answers**
	Received ☐

Cardiac Exercise test (every second year)	**Comment on all positive answers**
Age > 40 years (or if requested by the doctor)	**Completed** ☐

Physical Examination

Name : _____ **date** _____

Female ☐ **Male** ☐

Height _____ **m** **Weight** _____ **kg** **BMI** _____ **kg/m²** **BT** _____/_____

Caput/facies **Ears** **Eyes** **Cavum oris /teeth/ dentures**	**Comment on all abnormalities** **Normal** ☐
Collum **Lymph nodes** **Gl.Thyroidea** **Collum/mobility**	**Comment on all abnormalities** **Normal** ☐
Skin	**Comment on all abnormalities** **Normal** ☐
Pulmones St.p	**Comment on all abnormalities** **Normal** ☐
Cor St.c. / Signs of incompensation	**Comment on all abnormalities** **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_____