

Supplementary Questionnaire 1, Lundberg et al.

HEALTH DECLARATION

Date _____

Date of birth _____

Name _____

Address _____

Mailing address _____

E-mail _____

Phone home _____ work _____ mobile _____

Height _____

Weight _____

Do you have, or have you previously had:	Yes	No	Comment
Asthma or other lung disease?	ÿ	ÿ	_____
Other allergic problems?	ÿ	ÿ	_____
Blood disease?	ÿ	ÿ	_____
Diabetes? Egg whites. sugar in the urine?	ÿ	ÿ	_____
Heart disease? Elevated blood pressure? Vascular	ÿ	ÿ	_____
disease?Joint or muscle disease? Back problems?	ÿ	ÿ	_____
Knee injury or knee problems? Other damage?	ÿ	ÿ	_____
Dizziness? Fainting? Epilepsy?	ÿ	ÿ	_____
Nose or throat infection	ÿ	ÿ	_____
Headaches (frequent, long-lasting or migraine)?		ÿ	_____
Do you take painkillers because of the pain?	ÿ	ÿ	_____
Other long lasting or serious illness/injury?Prescribed	ÿ	ÿ	_____
medications for long-term use?	ÿ	ÿ	_____
In addition, answer the following questions:			
Do you smoke? If yes, how much?	ÿ	ÿ	_____
Do you use snus? If yes, how much?	ÿ	ÿ	_____
Do you use any medication regularly?	ÿ	ÿ	_____

Do you take any food supplement?

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Do you feel completely healthy right now?

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I certify that the above information has been truthfully entered by me:

Signature_____

Any additional comments:

Thank you for your participation!