Translation of Declaration of Health

("Hälsodeklaration", form TSTRK1002)

1. Do you have any visual disorders?

a) involuntary movement of the eye (nystagmus)
b) visual field defects (such as limited wide angle vision)
c) double vision (diplopia)
d) nightblindness (markedly impaired vision in the dark)
e) any other eye disease?

2. Have you ever suffered sudden disturbances of balance or sudden dizziness?

3. Do you suffer from any disease or physical impairment that affects your mobility? If so, what kind of disease or impairment?

4. Have you ever suffered from any cardiovascular disease, such as stroke (cerebral haemorrhage, cerebral thrombosis), angina pectoris, heart attack, arrhythmia, impaired valve function or any other cardiovascular disease?

If so, which disease have you suffered from, and when?

5. Do you have diabetes?

If so, what treatment du you get?
diet tablets insulin

If your diabetes is treated with tablets or insulin, you will have to submit a medical certificate regarding your disease.

6. Have you ever suffered from any neurological disorder?

7. a) Have you ever suffered from epilepsy or had an epileptic seizure?
b) Have you ever had a convulsion, fainted or experienced any other disturbance of consciousness?

8. Have you ever had severely reduced kidney function?

9. Du you suffer from dementia or any cognitive disorder, such as attention, judgement or memory disorder?

10. Have you ever suffered from any disease involving sleep or alertness disorder, such as sleep apnoea, snoring disease or narcolepsy?

11. Have you ever been dependent on or addicted to alcohol, drugs or pharmaceuticals.

If so, how long ago?

12. Have you ever suffered from any mental disease or disturbance, such as schizophrenia or other psychotic disorder, or bipolar (manic-depressive) disorder?

13. Do you have ADHD, ADD, DAMP, autism spectrum disorder (such as Asperger's syndrome), Tourette syndrome or mental retardation?

14. Have you been treated in hospital or been in contact with a doctor regarding any of the above (questions 1-13)?

If so, when?

Please state the name of the healthcare provider or clinic:

What was the reason for this treatment or contact?

15. Do you take medicine on a regular basis?

If so, what medicine or medicines?

You do not need to list birth control pills, vitamins, over-the-counter (OTC) allergy medicine, or treatment for skin diseases.

Please note that the Patient Information Leaflet (PIL) included in the medicine's package contains important information about your medicine in relation to road safety.

16. Do you have any further information that you wish to share with the Swedish Transport Agency?

If so, what information is that?

Anyone who, intentionally or through negligence, submits incorrect information may be fined for doing so.

I hereby certify that the information given above is correct and up to date.