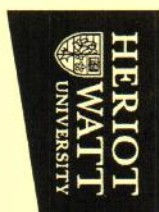


Confidential University Health Service Medical Questionnaire



Please answer all questions

Campus (please tick)	Edinburgh <input type="checkbox"/>	Scottish Borders <input type="checkbox"/>
Surname:		
Forenames:		
Date of Birth:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Single <input type="checkbox"/>	Married <input type="checkbox"/>	Number of children (if any):
Nationality:		
Home Address:		
	Post Code:	
Telephone Number:	Mobile Telephone Number:	
Last School or University:		
Last Doctor:		
Post Code:	Telephone Number:	
Undergraduate <input type="checkbox"/>	Postgraduate <input type="checkbox"/>	Year of Entry: 20__
University School & Course:		
Please state term address (if known)		
Home <input type="checkbox"/>	Hall <input type="checkbox"/>	Lodgings <input type="checkbox"/>
		Flat <input type="checkbox"/>
Height: _____ metres	Weight: _____ kilos	
Smoking status:	Never smoked <input type="checkbox"/>	Ex-smoker <input type="checkbox"/>
		Smoker _____ per day

The form continues on the reverse side

Pre-University Vaccinations	Approx. Dates
Tetanus Toxoid	
Polio/myelitis	
Mumps/Measles/Rubella	
B.C.G. (Tuberculosis)	
Meningitis A C W Y	
Others (specify):	
Date and result of last cervical (Pap) smear:	Date next smear due:
Do you suffer or have you suffered from any of the following? If any answers are YES would you please give details:	
Asthma or other respiratory disorders	yes <input type="checkbox"/> no <input type="checkbox"/>
Diabetes	yes <input type="checkbox"/> no <input type="checkbox"/>
Fits (Epilepsy)	yes <input type="checkbox"/> no <input type="checkbox"/>
Heart problems/heart pacemaker	yes <input type="checkbox"/> no <input type="checkbox"/>
Thyroid problems	yes <input type="checkbox"/> no <input type="checkbox"/>
Have you ever had psychiatric treatment	yes <input type="checkbox"/> no <input type="checkbox"/>
Depressive illness	yes <input type="checkbox"/> no <input type="checkbox"/>
Anaemia	yes <input type="checkbox"/> no <input type="checkbox"/>
Bladder or kidney problems	yes <input type="checkbox"/> no <input type="checkbox"/>
Blindness or eye problems	yes <input type="checkbox"/> no <input type="checkbox"/>
Deafness or ear problems	yes <input type="checkbox"/> no <input type="checkbox"/>
Digestive problems	yes <input type="checkbox"/> no <input type="checkbox"/>
Drug sensitivity/allergy	yes <input type="checkbox"/> no <input type="checkbox"/>
Eczema or other skin problems	yes <input type="checkbox"/> no <input type="checkbox"/>
Hay fever or other allergies	yes <input type="checkbox"/> no <input type="checkbox"/>
Hereditary diseases	yes <input type="checkbox"/> no <input type="checkbox"/>
Migraine	yes <input type="checkbox"/> no <input type="checkbox"/>
Specific learning difficulties eg dyslexia	yes <input type="checkbox"/> no <input type="checkbox"/>
Tuberculosis	yes <input type="checkbox"/> no <input type="checkbox"/>
Any other serious illness (specify)	yes <input type="checkbox"/> no <input type="checkbox"/>
Any operations (specify)	yes <input type="checkbox"/> no <input type="checkbox"/>
Any serious deformity or disability	yes <input type="checkbox"/> no <input type="checkbox"/>
If any of these conditions or their effects still trouble you please give further details.	
Are you at present receiving any medical treatment?	
no <input type="checkbox"/> yes <input type="checkbox"/> (please specify)	
What is your average weekly alcohol intake?units per week	
Do you play sport or exercise regularly? yes <input type="checkbox"/> no <input type="checkbox"/>	
Have you any other condition which you think might be troublesome to you while at University? (please specify)	