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**University Health Service Medical Questionnaire**

This questionnaire is confidential

Please answer all the questions below:

**Patient Details (please print details):**

|  |  |
| --- | --- |
| **Sex:** | **Male □ Female □ Other (please specify):** |
| **Surname:** |  |
| **First Name:** |  |
| **Date of Birth:** |  |
| **Marital Status:** | **Single □ Married □ Other:** |
| **University Term Time Address:** |  |
| **Mobile Phone Number:****(see text reminders for consent)** |  |
| **HWU Email address:** |  |
| **Nationality:** |  |
| **Home Address & telephone number:** |  |

**Text Reminders (please tick):**

□ I give permission for Riccarton General Practice to contact me via text message regarding my booked appointment, and relevant healthcare activities eg. chronic disease reviews. I understand that I may withdraw my consent for text reminders at any time and I will contact Riccarton General Practice if this is the case. Riccarton General Practice holds all patient information with the strictest confidence and abides by Data Protection Legislation.

**Course Details:**

|  |  |
| --- | --- |
| **HWU School & Course:** |  |
| **Undergraduate □ Postgraduate □** | **Year of entry:** **Length of course (number of years):** |

**Emergency Contact:**

Name.......................................................................... Relationship...................................................................

Telephone Number:..............................................................................................................................................

Other details:

|  |  |
| --- | --- |
| **Height:** | **Weight:** |
| **Smoking Status:** Never Smoked □ Ex Smoker □ | Current smoker (amount per day) □ \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Average Weekly Alcohol Intake (Units)**: | **Do you play sport/exercise regularly?**Yes □ No □ |

**Vaccination History:**

|  |  |
| --- | --- |
| **Pre-University Vaccinations** | **Approximate Dates** |
| Diphtheria/Tetanus/Polio  |  |
| Measles/Mumps/Rubella  | Dose 1: Dose 2: |
| BCG (tuberculosis) |  |
| Meningitis ACWY |  |
| Covid-19  | Name of vaccine: | Dose 1: Where (country): |
| Name of vaccine: | Dose 2: Where (country): |
| Others (please specify): |  |

Do you suffer or have you suffered from any of the following? If any answers are yes would you please provide details:

|  |  |  |
| --- | --- | --- |
| **Medical Conditions:** | **Please tick Yes or No** | **Date of Diagnosis (if known)/provide additional information:** |
| Asthma | Yes □ No □ |  |
| Other Respiratory Disorders | Yes □ No □ |  |
| Heart problems | Yes □ No □ |  |
| Hypertension | Yes □ No □ |  |
| Diabetes | Yes □ No □ |  |
| Thyroid problems | Yes □ No □ |  |
| Epilepsy (fits) | Yes □ No □ |  |
| Other Neurological problems | Yes □ No □ |  |
| Migraine | Yes □ No □ |  |
| Psychological Illness | Yes □ No □ |  |
| Have you ever had psychiatric treatment? | Yes □ No □ |  |
| Specific Learning Difficulties | Yes □ No □ |  |
| Gastrointestinal problems | Yes □ No □ |  |
| Bladder or kidney problems | Yes □ No □ |  |
| Blindness or eye problems | Yes □ No □ |  |
| Deafness or ear problems | Yes □ No □ |  |
| Eczema | Yes □ No □ |  |
| Other skin conditions | Yes □ No □ |  |
| Drug sensitivity/Allergies | Yes □ No □ |  |
| Hay fever | Yes □ No □ |  |
| Any other serious illness: | Yes □ No □ |  |
| Any operations: | Yes □ No □ |  |
| Any disability: | Yes □ No □ |  |

|  |
| --- |
| Are you at present receiving any medical treatment/medication? Yes □ No □ (if yes give details) |

**Cervical Screening:**

|  |
| --- |
| **Date of last cervical (Pap) smear (eligibility in the UK is from age 25)***Please include where it was taken, the result and the due date of next test. If previous test taken outside the UK, please provide a copy of your result.* |