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:**
Last School/University:	

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 - 1st	
Measles/Mumps/Rubella – 2nd	
BCG (tuberculosis)	
Meningitis ACWY	
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 serious deformity/disability	Yes □ No □	

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

<u>For Female Patients only:</u>

Date of last cervical (Pap) smear: *(please include where it was taken, the result and the due date of next test)*