Health History Form for students

Please answer each question and use capital letters!

Applicant number: _____ **Date of birth** (day/month/year)**:** _____

Family name: _____ **Given name(s):** _____

Place of birth (Town and country)**:** _____

Mother's maiden name (family name, given name)**:** _____

Address (house #, floor, door, street, town, country, postal code)**:** _____

Health insurance card # (if available)**:** _____

The following questions must be answered truthfully and to the best of your knowledge.

1) **Do your parents, brothers or sisters have any known illnesses (for example: high blood pressure, diabetes, asthma, bleeding disorders….)**
   Mother: _____
   Father: _____
   Brothers/Sisters: _____

2) **Do you have any known allergies (food, insect stings, penicillin, hay fever, other)?**
   Yes /specify: _____ No

3) **Have you ever undergone a surgery?** Yes /specify: _____ No
   Check the infectious diseases you have had:

Measles	Yes	No	**Chicken pox**	Yes	No	**Mumps**	Yes	No
Mononucleosis	Yes	No	**Tuberculosis**	Yes	No	**Hepatitis**	Yes	No

Have you ever tested positive for HIV? Yes No
Have you ever been treated with malaria? Yes No
List any other infectious diseases you have had: _____

4) **Have you ever lost consciousness:** Yes /when, how often: _____ No

5) **Have you ever had seizures:** Yes /when, how often: _____ No

6) **List chronic health concerns or illnesses you are currently treated with.**

_____

7) **Please list ALL current medications taken on a routine basis.**

I take no medications on a routine basis.
I take medications as stated below:
Med#1 _____ Dosage: _____ Reason for taking: _____
Med#2 _____ Dosage: _____ Reason for taking: _____

8) **Do you smoke?** No Yes, for _____ years, _____cigarettes/day

9) **Do you consume alcohol?** Never Rarely Weekly Daily

10) **Do you have a drivers' licence?** Yes No

11) **Have you been immunized against Hepatitis-B?** Yes No

I hereby certify that the information contained in the Health History Form is valid with regard to my current health status and correct to the best of my knowledge. If a change in my health status occurs, I agree to notify the Occupational Health Care Provider of the University of Pécs.

Date:

_____
Signature