Medical History Questionnaire

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NAME:	PLACE OF BIRTH:	DATE OF BIRTH
MOTHER'S MAIDEN NAME:	ADDRESS:	PHONE NUMBER:
CONTACT IN CASE OF EMERGENCY:		E-MAIL:

Family medical history

Please underscore the disease(s) that your family has ever had before.

diabetes / high blood pressure / haemophilia / jaundice / alcoholism / tuberculosis / asthma
psychiatric disorder / tumour

Please provide more details if necessary:

Earlier diseases, hospital care

Please underscore the disease(s) that you have ever had before.

hepatitis / syphilis / AIDS / herpes / other infectious disease / other: ....

Have you ever received hospital care? (surgical operations, bone fracture, etc.) yes / no

If yes, please list the most important instances of hospital care and the diseases by indicating the date of care (year).

Smoking (please underscore): Yes/No .... cigarettes a day	**Consumption of alcohol** (please underscore): never / once a month / once a week / several times a week	**Physical activity** (please underscore): active / moderately active / not active

Current physical status

height: .... cm	body weight: .... kg	blood pressure: ..../....... Hgmm

Do you have any dermatological problems? (please underscore) yes / no

If yes, please underscore the type of problem:

inflammation / eczema / psoriasis / other: ....

Eyesight: Do you wear glasses or lenses? yes / no

Do you have any ophthalmological diseases?

Hearing: Do you have a hearing disorder? right side / left side

Do you wear hearing aid? right side / left side

Are you on regular medication? yes / no (subject to prescription yes/ no)

If yes, please indicate the medicine(s) regularly taken.

Chronic diseases

Do you need regular medical attendance for any reason? (please underscore) yes/ no

If yes, please provide details.

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Do you have any mental disorder? yes /no If yes, please underscore the type of problem: common crying / distress / sleep disorder / prostration / depression / other: .... Have you ever had nausea with loss of consciousness? yes / no If yes, please provide details.
Do you have any allergy? yes /no If yes, please underscore the type of allergy: pollen / medicine / food / other: .... If you have any sensitivity to medications, please provide details:

Vaccinations Please indicate the vaccinations you have received		
Hepatitis B (EngerixB, HBVaxII, HBVaxPro)	yes / no /not sure	Date (year, month)
Hepatitis A (Havrix, Vaqta, Avaxim)	yes / no /not sure	Date (year, month)
Combined vaccine (HepA and B, Twinrix)	yes / no /not sure	Date (year, month)

Other:
Please provide further details, should you wish to add anything else regarding your health conditions.

I can confirm that, I have provided all information I am aware of regarding my health condition, and these details represent the truth. Furthermore, I confirm that I will report any infectious or other, not infectious but more serious diseases I may have during my university studies at the competent healthcare service.

I understand that, any health related data obtained by the healthcare service shall be processed as per the terms of the CXII. Act of 2011 on self-determination and freedom of information, the XLVII. Act of 1997 on the processing and protection of medical and other related personal data, and the Regulation (EU) 2016/679 (27 April 2016) on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC.

Budapest, ... 2018

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signature

This document was prepared in accordance with the Medical History Questionnaire used by the University of Debrecen and provided by the president of the Clinical Centre on 18 July 2018.