University Health Service

Confidential
Medical History Questionnaire

Please complete this form, and then ENSURE that you bring it with you when you come to your Health Centre registration session.

Surname (family name) ..... Mr / Mrs / Miss / Ms

First name (given name) ..... Male / Female

Middle name .....

Preferred name .....

Address (whilst at University) .....

..... Post code .....

Date of birth .....

Mobile telephone .....

Email .....

Course .....

Length of course .....

Ethnicity	

Main spoken language	

Height (cm)..... Weight (kg) .....

Have you ever smoked? ..... Yes / No

Do you still smoke? ..... Yes / No

If yes, number per day .....

Do you drink alcohol? ..... Yes / No

If yes, how many units per week ..... (1 unit=1 measure spirit / 1 glass wine / half pint beer)

Females over 25, do you wish to attend for cervical screening ..... Yes / No

Carers

A Carer is anyone who looks after a family member, partner or friend, who needs help because of their illness, frailty, disability, mental health problem or an addiction and cannot cope without the carer's support.

Are you a Carer? .....Yes / No If yes, since when? .....

Data Sharing

Your Data Matters to the NHS. Information about your health and care helps us to improve your individual care, speed up diagnosis, plan your local services and research new treatments. The NHS is committed to keeping patient information safe and always being clear about how it is used. We only share your information with other NHS organisations under certain conditions and if it is relevant to your health care but if you do not want your confidential patient information shared in this way, you have a number of choices. Please visit our practice website for more information. Please visit the web pages on data Choices and Summary Care Records.

Continued overleaf

Current personal medical history

Have you **currently** any of the following?	YES	Date of Onset	
High blood pressure			
Atrial fibrillation			
Heart disease			
Diabetes			Last HbA1c (if known)
Asthma			Peak flow (if known)
Epilepsy			
Thyroid problems			
Chronic Kidney disease			
Depression			Are you on medication
Schizophrenia			
Bipolar affective disorder (manic depression)			

Have you ever had any of the following medical conditions ? Please circle if yes.

Cancer Serious Mental Health Problems / Psychosis Eating Disorder

Please give details of any surgical operations or serious medical problems (with dates)

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Are you currently taking any prescribed medication?

Name, Strength and Dose ....

Name, Strength and Dose ....

Name, Strength and Dose ....

Are you allergic to any medication? .....

Do you consider yourself to have a learning disability or any other disability that you would like us to know about? .....

.....

Please complete immunisation record as below. If dates unknown; please state Yes or No.

If you are unsure if you have had the vaccines, we advise that you have them. It is not harmful to have additional vaccines.

Measles / Mumps / Rubella (MMR) - 2 doses required.

1st Dose ..... 2nd Dose .....

Meningitis ACWY - 1 Dose required .....

FEMALES ONLY UNDER THE AGE OF 25 :

HPV Vaccine -2 Doses needed if received 1st dose before the age of 15.
3 Doses needed if received first dose after the age of 15.

1st Dose ..... 2nd Dose ..... 3rd Dose .....