

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