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
First name (given name) .... Male / Female
Address (whilst at University) ....
.... Post code..............................
Date of birth..
Mobile telephone..
Email..
Course..
Length of course..
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
(1 unit=1 measure spirit / 1 glass wine / half pint beer)
If yes, how many units per week ....
Females over 25, do you wish to attend for cervical screening .... Yes / No

Ethnic Group	✔	Additional Info
White British		
White Irish		
Other White		
Indian		
Pakistani		
Bangladeshi		
Chinese		
Caribbean		
African		
Other Asian		
Not given / refused		

Main spoken language	

Current personal medical history

Have you **currently** any of the following?	YES	NO	Date of Onset		
High blood pressure					
Atrial fibrillation					
Heart disease					
Diabetes				Last HbA1c (if known)	
Asthma				Peak flow (if known)	
Epilepsy				Date of last fit	
Thyroid problems					
Chronic kidney disease					
Depression				Are you on medication	
Schizophrenia					
Bipolar affective disorder (Manic depression)					

Continued overleaf

Past personal medical history

Have you **ever** had?	YES	NO	Date of Onset
Cancer			
Stroke			
Migraine			
Depression			
Psychosis/Serious Mental Health Problem			
Eating Disorder (bulimia or anorexia)			

Please give details of any surgical operations or serious medical problems (with dates). Do you have a learning disability or any other disability you would like us to know about?

....

....

....

			Since
Are you a carer?			

Please complete immunisation record

Measles / Mumps / Rubella (MMR) – 2 doses required

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

Meningitis ACWY

Date of vaccination ....

Are you allergic to any medicines? YES / NO If YES, please specify

Are you currently taking any prescribed medication? YES / NO (include inhalers and creams)

Name..

strength..

dose..

Name..

strength..

dose..

Has anyone in your family had: If YES, which family member

Diabetes YES / NO ....

High Blood Pressure YES / NO ....

Has anyone in your immediate family suffered a heart attack before the age of 60? YES / NO

Has anyone in your immediate family suffered a stroke before the age of 60 YES / NO

We occasionally contact patients by text messages, to remind them of important appointments, if they need to contact the health centre or to give them results of a test. If you don't wish to be contacted by text message please tick the box ☐

Enhanced Data Sharing model

Our patient date system is able to share record with other services such as community services and Out of Hours. We will also request to receive information from these same healthcare providers when you have accessed their services to help to help you have continuity of care.

Your information is only shared with registered healthcare providers. If you **DO NOT WISH** for us to share your record then please tick the boxes below.

I dissent to my record being shared out to healthcare services ☐

I dissent to the University Health Centre receiving information from healthcare services you have accessed. ☐

Thank you for completing this form. Don't forget to bring it with you to your Health Centre registration.

Please inform us if you have any communication needs such as an interpreter, hearing loop, advocates, of if you require information in large print or braille.