**Health history form for students**
Please answer each question and use capital letters.

Name:..... Faculty/Spec.: .....

Place and date of Birth ( day / month / year ):

.....

Mother's maiden name: .....

Address: .....

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
4. **Check infectious diseases you have had:**

   ***Measles:*** Yes No ***Chicken pox:*** Yes No ***Mumps:*** Yes No ***Mononucleosis:*** Yes No
   ***Tuberculosis:*** Yes No ***Hepatitis:*** Yes No
5. **Have you ever tested positive for HIV?** Yes No
6. **Have you ever been treated with malaria?** Yes No
7. **List any other infectious diseases you have had:**
8. **Have you ever lost consciousness:** Yes / when, how often: No
9. **Have you ever had seizures:** Yes / when, how often: No
10. **List chronic health concerns or illnesses you are currently treated with**.
11. **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:
12. **Do you smoke?** No Yes, for.... years, ..... cigarettes/day
13. **Do you consume alcohol?** Never Seldom Weekly Daily
14. **Do you have a drivers' licence?** Yes No
15. **Have you been immunized against Hepatitis-B?** Yes No

I hereby certify that the information contains int he 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