

Medical History Form

All questions asked in this questionnaire are strictly confidential and will become part of your medical record.

Last Name	First Name:	Date of Birth:	Otago University Student ID:

Are you allergic to any medication/ medical supplies? (please circle answer)	
NO	YES <i>(If yes, please specify, including reaction)</i>

Have you ever had an anaphylactic reaction? (please circle answer)	
NO	YES <i>(If yes, please specify, to what)</i>

Do you have a disability? (please circle answer)	
NO	YES <i>(If yes, please specify)</i>

Please list any medication that you are currently taking: including contraceptives, inhalers, pharmacy meds/ herbal etc

Your medical history: Do you have any serious/ongoing medical conditions/ major illness/ major operation or significant illness?	
NO	YES <i>If yes, please circle and provide as much detail as possible including age of onset.</i>

Asthma	Type 1 or 2 Diabetes	Epilepsy	Cardiovascular Disease/ High Blood Pressure
Rheumatic Fever	Coeliac Disease/ Ulcerative colitis/ Crohn's Disease	Significant Surgery/ Injuries	
Cancer <i>(Type)</i>	Immunocompromised – Condition:	Other:	

Do you have any mental health issues: including anxiety/ depression/ eating disorders (please circle answer)	
NO	YES <i>if yes, please specify.</i>

Family Medical History: Does any of your family have any serious medical/ mental health conditions? (please circle answer)	
NO	YES <i>if yes, please specify and provide as much detail as possible below</i>
Medical/ Mental Health Condition:	Family member & age of onset:

Lifestyle information: please circle option that applies.
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Never Smoked	Current Smoker – Amount:	Social Smoker – Amount:	Ex Smoker <12 months > 12 Months
Never Vaped	Current Vaper	Social Vaper	Nicotine No Nicotine Ex Vaper <12 months > 12 Months

How often do you have a drink containing alcohol? – please circle answer				
Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week

How many standard drinks containing alcohol do you have on a typical day you are drinking?				
1-2	3-4	5-6	7-9	10+

How often do you have 6 or more drinks on one occasion?				
Never	Less than monthly	Monthly	Weekly	Daily/ or almost daily

Do you have any concerns about your use of alcohol or other drugs?	NO	YES
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Vaccinations: Please circle the option that best describes your immunisation status	
I have had all my childhood vaccinations.	Unvaccinated/ Don't know
Gardasil/ HPV vaccinations are FREE for domestic students aged 9 – 26 year olds- please ask your clinician	

Screening History – for domestic students only: (if applicable) (please circle answer)	
Have you ever had a cervical HPV screening?	NO YES If yes, in which country/ city was it done and year?
Year of last mammogram (applies to 45+ only):	Screening History questions Not Applicable be to me: