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** *(If yes, please specify, including reaction)*

Have you ever had an anaphylactic reaction? (please circle answer)

NO **YES** *(If yes, please specify, to what)*

Do you have a disability? (please circle answer)

NO **YES** *(If yes, please specify)*

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** *If yes, please circle and provide as much detail as possible including age of onset.*

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 *(Type)* Immunocompromised – Condition: Other:

Do you have any mental health issues: including anxiety/ depression/ eating disorders **(please circle answer)**

NO **YES** *if yes, please specify.*

Family Medical History: Does any of your family have any **serious** medical/ mental health conditions? **(please circle answer)**

NO **YES** *if yes, please specify and provide as much detail as possible below*

Medical/ Mental Health Condition: Family member & age of onset:

Lifestyle information: please circle option that applies.

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

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:**

Authorised by: Last updated: 19/12/2023