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 number

Are you allergic to any medications/ medical supplies?

NO ☐ **YES** ☐ *(if yes, please specify, including reaction)*

Have you ever had an anaphylactic reaction?

NO ☐ **YES** ☐ *(if yes, please specify to what)*

Do you have a disability?

NO ☐ **YES** ☐ *(if yes, please specify)*

Please list any medications that you are currently taking, *including contraceptives, herbal and over the counter medications:*

Your medical history: *Do you have any significant/ongoing medical conditions/ major illness/ major operation or significant illness?*

NO ☐ **YES** ☐ *(if yes, please list, e.g. asthma, DVT, etc):*

Do you have any mental health issues? (including anxiety/depression/eating disorders)

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

Family Medical History: *Does any of your family have any* ***significant*** *medical/mental health conditions?*

NO ☐ **YES** ☐ *(If yes, please specify family member/condition) e.g. Mum – asthma*

Lifestyle Information: *please circle option that applies*

never smoked ex-smoker current smoker – *amount:*

social smoker – *amount:* current vaper

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 when 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 I have been partially vaccinated Unvaccinated Unsure

Have you completed your HPV (Gardasil) vaccinations? NO YES Unsure

Women's Health History (if applicable)

Have you ever had a cervical screening? **NO YES If yes, was it normal and when was it done**

Year of last mammogram (applies to 45+ only):