

Strathcairn Medical Practice

St Andrews Community Hospital
Largo Road, St Andrews, Fife, KY16 8AR
Tel 01334 473441 Fax 01334 465677



STUDENT MEDICAL QUESTIONNAIRE

This questionnaire is from the doctor's practice with whom you will be registered while you are at University and is to help us get to know you. The information you give will be treated confidentially and will not be disclosed to the University or to any other party.

Please bring your medical card and/or completed Registration Form (GPR) with you to Matriculation where staff from the Health Centre will receive them. (Additional space for answers is provided on page 4).

1. Contact information

Mr/Mrs/Miss/Ms/Other _____ Surname _____ Forename _____

Date of birth _____ Sex: M F Student ID No _____

Term-time address: House no. _____ or Hall name _____

_____ Post code _____

House telephone number _____ Mobile no. _____

Expected end date of university course _____

University email _____@st-andrews.ac.uk

PLEASE INFORM RECEPTION OF ANY CHANGE OF CONTACT INFORMATION.

2. Height and Weight

Height _____ Weight _____

3. Do you OR have you ever smoked? Yes No If YES please complete the following:

Current smoker 1-9 per day 10-19 per day 20-39 per day

Ex-smoker 1-9 per day 10-19 per day 20-39 per day Year stopped _____

4. Do you drink alcohol? Yes No If YES please complete the following:

Less than 1 unit/day 1-2 units per day 3-6 units per day 7-9 units per day

More than 9 units per day

5. Past medical history - Please list all important illnesses, including hospital admissions and operations. (Continue on page 4 if necessary)

Date _____ Description _____

Date _____ Description _____

Date _____ Description _____

6. Immunisations - state dates received in the boxes below

1st Diphtheria Date:	1st Tetanus Date:	1st Pertussis Date:	1st Polio Date:	1st Hib Date:
2nd Diphtheria Date:	2nd Tetanus Date:	2nd Pertussis Date:	2nd Polio Date:	2nd Hib Date:
3rd Diphtheria Date:	3rd Tetanus Date:	3rd Pertussis Date:	3rd Polio Date:	3rd Hib Date:
1st Meningitis C Date:	2nd Meningitis C Date:	Booster Hib/Men C Date:		
1st Pneumococcal Date:	2nd Pneumococcal Date:	3rd Pneumococcal Date:		
1st Measles / Mumps / Rubell Date:		2nd Measles / Mumps / Rubell Date:		
Booster Diphtheria Date:	Booster Tetanus Date:	Booster Pertussis Date:	Booster Polio Date:	
1st Hepatitis A Date:	2nd Hepatitis A Date:	Booster Hepatitis A Date:		
1st Hepatitis B Date:	2nd Hepatitis B Date:	3rd Hepatitis B Date:	Booster Hepatitis B Date:	
1st Typhoid Date:	Booster Typhoid Date:	Yellow Fever Date:		

Any other immunisations

7. Medication

Are you taking any regular medicines (incl. oral contraception) from your doctor/chemist? Yes No

If YES, please state:

Name _____ Dose and frequency _____

Name _____ Dose and frequency _____

Name _____ Dose and frequency _____

8. Allergies

Do you have any allergies including allergies to medicines Yes No If YES, please state below:

9. Females only

Have you ever had a cervical/PAP smear? Yes No If YES, please state:

Date _____ Which clinic carried out the procedure _____

Result of smear: Negative/Normal Abnormal Date next smear due (if known) _____

10. Next of kin

Name, address and telephone number of your next of kin.

11. Family history

Have any of your relatives had or have

		Relative/s affected		Relative/s affected
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
High blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____		

12. Is there any health issue you would like us to know about? Yes No

Should you have any medical problem requiring ongoing input please make an appointment to discuss this.

13. Ethnicity

White Scottish White British Other white ethnic group please state _____

Asian British Asian other please state _____

Black British Black other please state _____

Other ethnic group - please state _____

I prefer **not** to state my ethnic group

Additional information - Please state the question the additional information relates to.