Health Questionnaire

Name:	
Date Of Birth (Dd/Mm/Yyyy):	
Place Of Birth:	
Mother's Maiden Name:	
Permanent Address:	
Phone Number:	
E-Mail:	
Contact Person (In Case Of Emergency):	
Program/Faculty:	

Family medical history

Please underscore the disease(s) that your family has ever had before.
diabetes mellitus / high blood pressure / hemophilia / jaundice / alcoholism / tuberculosis / asthma / psychiatric disorder / cancer
Please provide more details if necessary:

Previous diseases, hospital care

Please underscore the disease(s) that you have ever had before.
hepatitis / syphilis / AIDS / other infectious disease / other: ....

Have you ever received hospital care? (surgeries, bone fractures, etc.) Yes / No
If yes, please list the most important instances of hospital care and the diseases by indicating the date of care (year).

Current physical status

height: .... cm	body weight: .... kg	blood pressure: ...... /....... mmHg
Smoking (please underscore): Yes/No .... cigarettes a day	**Consumption of alcohol** (please underscore): never/once a month/once a week/ several times a week	**Physical activity** (please underscore): active/moderately active /not active

Eyesight: Do you wear glasses or lenses? Yes / No
Do you have any ophthalmological disease?

Hearing: Do you have a hearing disorder? right side / left side
Do you wear hearing aid? right side / left side

Chronic conditions/diseases	
Do you need regular medical attendance for any reason? If yes, please provide details.	Yes / No
Are you on regular medication? If yes, please indicate the medicine(s) regularly taken.	Yes / No
Do you have any mental disorder? If yes, please underscore the type of problem: common crying / anxiety / sleep disorder / depression / other:	Yes / No
Have you ever experienced loss of consciousness? If yes, please provide details.	Yes / No
Do you have any dermatological problems? If yes, please underscore the type of problem: inflammation / eczema / psoriasis / other:	Yes / No
Do you have any allergy? If yes, please underscore the type of allergy: pollen / medicine / food / other: .... If you have any hypersensitivity to medications, please provide details:	Yes / No
Other:	
Please provide any further details, should you wish to add anything else regarding your health condi-tions.	

I hereby confirm that I have provided all information I am aware of regarding my health condition, and these details represent the truth. Furthermore, I confirm that I will report any infectious or other, not infectious but more serious diseases I may have during my university studies at the competent healthcare service.

I understand that, any health-related data obtained by the healthcare service shall be processed as per the terms of the CXII. Act of 2011 on self-determination and freedom of information, the XLVII. Act of 1997 on the processing and protection of medical and other related personal data, and the Regulation (EU) 2016/679 (27 April 2016) on the protection of natural persons with regard to the processing of personal data and on the free move-ment of such data, and repealing Directive 95/46/EC.

Debrecen, ...

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signature