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|  | Health questionnaire  for candidates applying for 6-yr Medicine Program at Collegium Medicum in 2022/2023 |

# Instructions

This health questionnaire should be filled with capital letters by a practising physician ONLY. You should bring the ORIGINAL questionnaire along with other required documents until **24/09/2022** to the university. Copies will be disregarded.

# Personal data

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name and surname |  | | Street address,  including city,  and postal code |  |
|  | |
|  | | | | |
| Date of birth (YYYY-MM-DD) **\*must be 18 years old on 1st Oct 2021** | |  | Country |  |

# Medical record

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | No |  | Yes |  | If, yes describe the type |
|  |  |  |  |  |  |
| congenital or acquired disability |  |  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |  |  |
| chronic conditions: diabetes, asthma, hypertension, rheumatic, allergy, psychiatric, neurological, others |  |  |  |  |  |
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|  |  |  |  |
|  |  |  |  |  |  |
| medication (temporary/ longstanding) |  |  |  |  |  |
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|  |  |  |  |  |  |
| hospitalization (dates, diagnosis) |  |  |  |  |  |
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|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  | **No** |  | **Yes** |  | **If, yes describe the type** |
| family diseases |  |  |  |  |  |
|  |  |  |  |
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| other information |  |  |  |  |  |
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# Medical examination

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **General information** | | | | | | | | |
| Hight in cm |  | | | Wight in kg |  | | Pulse | per min |
|  |  | | |  |  | |  |  |
| Blood pressure |  | | | |  | |  |  |
|  |  | | |  |  | |  |  |
| **Physical examination of the systems (insert X if applicable)** | | | | | | | | |
|  |  |  | | Healthy |  |  | Further tests needed | |
| **Vision (insert X if applicable)** | | | | | | | | |
|  |  |  | | Normal vision |  |  | Glasses needed | |
|  |  |  | |  |  |  |  |  |
|  |  |  | |  | Rt |  | Colours |  |
|  |  |  | |  |  |  |  |  |
|  |  |  | |  | Lt |  |  |  |
| **Was the general blood and urine tests made? (insert X if applicable)** | | | | | | | | |
|  |  | |  | Yes |  |  | No |  |

# Vaccinations

Vaccine against Hepatitis B is mandatory. In exceptional cases, individualdoses can be taken later.

Vaccination against Covid-19 is strongly recommended.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Hepatitis B** |  |  |  |  |  |  |  |  |
| 1st dose date |  |  | 2nd dose date |  |  | 3rd dose date |  |  |
|  |  |  |  |  |  |  |  |  |
| Vaccine name and serial number |  |  | Vaccine name and serial number |  |  | Vaccine name and serial number |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Covid-19** |  |  |  |  |  |  |  |  |
| 1st dose date |  |  | 2nd dose date |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Vaccine name and serial number |  |  | Vaccine name and serial number |  |  |  |  |  |

# Conclusion

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | I agree |  | I disagree |
| Candidate is in a good health and hence able to commence medical studies | |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature |  |  | Name |  |
|  |  |  |  |  |
|  | Signature of the physician filling this form |  |  | Name of the physician filling this form |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Signature |  |  |  |  |  | Stamp |  |
|  | MM |  | DD |  | YY |  |  |