OCCUPATIONAL HEALTH QUESTIONNAIRE

for medical fitness examinations

Please read the following questions carefully and answer them to the best of your knowledge. Your personal and medical data will be handled conidentially and will be accessible only to the occupational health service. **Please mark your answer (by underlining or circling) even if your answer is „No". In case you answer „Yes", please give details.**

First / Given Name(s): .... **Last / Family Name(s):** ....

Mother's Name: .... **Place of Birth:** .... **Date of Birth:** ....

Address in Hungary: .... **Nationality:** ....

Telephone No. (Hun): .... **E-mail:** .... (for communication purposes only)

Highest level of education: .... **Acquired profession (if any):** ....

Current university studies – Faculty, Specialty: .... **Year:** .... **Group:** ....

....

Do you have any health complaints at the moment? No / Yes: ....

Do you have any chronic diseases or are you under medical care for any conditions ? (e.g.; hypertension, asthma, diabetes, anaemia, epilepsy, mental disorder, liver or kidney disease, etc.)
No / Yes: ....

At present do you suffer from any disease causing immunodeficiency or are you under any immunosuppressive treatment? No / Yes (please speciy): ....

Do you take any medicines regularly? No / Yes (please list): ....

Are you allergic to any drugs or other substances? No / Yes (please list): ....

Have you had any surgeries, major accidents or injuries? No / Yes (pls list with dates): ....

Have you ever had a loss of consciousness or a seizure? No / Yes (when?): ....

In case of ladies, are you pregnant? No / Yes: ....

Do you wear eyeglasses or contactlenses? No / Yes: Dioptres? Right: .... Left: ....

Body weight: .... kg Height: .... cm Do you smoke? No / Yes: .... cigarettes a day

Do you consume alcohol: No / Rarely / Occasionally Do you drink cofee? No / Yes: .... times a day

Your Vaccinations against Hepatitis B (list dates of vaccinations): ....

Are you vaccinated against Morbilli (measles)? No / Yes (give dates): ....

Are you vaccinated against Varicella (chickenpox)? No / Yes (give dates): ....

Are there any chronic diseases (e.g.: hypertension, diabetes, asthma, cancer, etc.) in your close family members (parents, siblings, children)? No / Yes: ....

I declare that I answered the above questions truthfully and I do not hide any disease.

Date: .... Signature: ....