

**UNIVERSITY OF MALTA
INSTITUTE OF HEALTH CARE**

**MEDICAL QUESTIONNAIRE
CONFIDENTIAL**

(TO BE COMPLETED BY THE STUDENT WITH THE HELP OF THE FAMILY DOCTOR)

A. PERSONAL INFORMATION

Course _____

Student's Name _____

Student's Address _____

I.D. Number _____ Date of Birth _____

Height _____ Weight _____

Name and Address of your General Practitioner _____

If registered disabled, give number and reason _____

What is your current daily/weekly intake of:

ALCOHOL: Day _____ Week _____

TOBACCO: Day _____ Week _____

Do you have a history of substance abuse? _____

B. MEDICAL HISTORY

Please circle relevant response

Have you, at any time, suffered from: REMARKS

- | | | | |
|----|---|----|-----|
| 1. | Depression, anxiety, nervous illness/breakdown | NO | YES |
| 2. | Faints, fits or disease of balance or nervous system | NO | YES |
| 3. | Hearing impairment | NO | YES |
| 4. | Colour blindness | NO | YES |
| 5. | Allergies or sensitivities or reactions to immunisation | NO | YES |
| 6. | Back problems | NO | YES |

List the dates and details of all current immunisations:

Signature of Family Doctor _____

C. DECLARATION

I declare that the above answers are true and complete to the best of my knowledge and belief. I understand that acceptance into an IHC Course is subject to successful completion of a medical test.

Signature of Student _____

Date _____

The completed medical questionnaire must be returned **either**:

personally to: Ms Elaine Xerri
Institute of Health Care,
Room 402,
Block A, Level 1,
Mater Dei Hospital

or by post to: Ms Elaine Xerri
Institute of Health Care
University of Malta
Msida