Pipeland Medical Practice
St Andrews Community Hospital
Largo Road, St Andrews,
Fife, KY16 8AR

Tel 01334 476840
Fax 01334 465632
www.pipelandmedical.com

Pipeland
MEDICAL PRACTICE

Complete and save/print using Acrobat or print and fill-in by hand. Return by post or drop into the practice at the above address.

STUDENT MEDICAL QUESTIONNAIRE

This medical questionnaire is the basis of your medical summary. Please be accurate with information. Overseas students must remember to bring consultant documentation before regular medication can be issued.

Please bring your completed Registration Form (GPR), ID, Letter of Accommodation and any relevant Visa/ Permit/Health Card (EHIC) with you to Matriculation where staff from the Health Centre will receive them.

1. Contact information

Surname ____________ Forename ____________ Mr/Mrs/Miss/Ms/Other ________

Date of birth (dd.mm.yy) _____ _____ _____ Sex: M ☐ F ☐ Student ID no. ____________

Term-time address: House no. _______ Room no. _______ Hall name ____________

Other ____________ Post code ____________

House tel no. ____________ Mobile tel no. ____________

Expected end date of course _____ _____ _____ University email ____________ @st-andrews.ac.uk

I consent to be contacted by: Text ☐ Email ☐

2. Next of kin

Name ____________ Telephone no. ____________

PLEASE INFORM PRACTICE OF ANY CHANGE OF CONTACT INFORMATION.

3. Past medical & surgical history

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

i) ____________ ii) ____________

iii) ____________ iv) ____________

v) ____________ vi) ____________

4. Medication

Are you taking any regular medicines, including oral contraception from your doctor or chemist?

Yes ☐ No ☐ If YES, please state:

Name ____________________ Dose and frequency ____________________

Name ____________________ Dose and frequency ____________________

Name ____________________ Dose and frequency ____________________

Name ____________________ Dose and frequency ____________________

5. Allergies

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

Medicine ____________________ Reaction ____________________

Medicine ____________________ Reaction ____________________

6. Height and Weight

Height ____________ cm Weight ____________ kg

7. 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 ____________

8. 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 ☐

9. Females only

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

Date smear taken ____________ What clinic carried out the procedure ____________

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

10. 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 / Rubella Date:		2nd Measles / Mumps / Rubella 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:		
Meningitis ACWY Date:	1st HPV Date:	2nd HPV Date:	3rd HPV Date:	

Any other immunisations

11. Family history

Have your mother, father or siblings ever been affected by any of the following:

	Relative/s affected		Relative/s affected
Asthma	________________	Epilepsy	________________
High blood pressure	________________	Diabetes	________________
Heart Disease	________________	Stroke	________________
Cancer	________________		

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

____

____

13. Registration options

Patients can register with the Practice of their choice. However for administration purposes only, students are registered alphabetically as follows:

A - Nt	Pipeland Practice	01334 476840
Nu - Z	Blackfriars Practice	01334 477477

If you wish to register with a specific Practice please let the member of staff dealing with your paperwork know in order that you are given the correct information.

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