Medical History Form

Please fill out and send directly (preferably NOT by Registered Mail) to:
Studenthelsetjenesten, P.O.Box 94 Blindern, N-0314 Oslo, Norway

Family/Surname: .....

First Name: ..... **Middle Name(s):** .....

Date of Birth – Day/Date: ..... **Month:** ..... **Year:** .....

Sex: ☐**M** ☐**F** **Civil Status** (e.g. single, married).....**Number of Children:** .....

Name of contact person (for use if you fall seriously ill and are unable to contact close relations yourself)

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This person's status (parent, other family - e.g. sister/uncle, or friend):.....

Contact person's complete address (street,city,country) and telephone number:

.....

.....

Your City and Country of Origin: .....

Programme: ☐Quota ☐NOMA☐ Exchange student ☐Self-financing Degree student ☐Other

Languages spoken: ☐English ☐ German ☐ French ☐ Norwegian ☐ Other-which?.....

Your recent Family Doctor's name:.....

Doctor's address, phone/fax-number and/or e-mail address:
(This is in case we need more detailed medical information about you that you do not recall.
Such contact is of course agreed upon with your doctor at the Student Health Services)

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Do you suffer from any chronic disease(s)? ☐**No** ☐**Yes**

If yes, which?.....

(Please write details; continue on back side if necessary).....

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Medication (incl. generic name and doses): .....

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Have you had any serious allergic reaction? ☐ **No** ☐ **Yes**

If yes, what did you react to? .....