GENERAL HEALTH PROFILING QUESTIONNAIRE FOR PUNJAB UNIVERSITY STUDENTS

Name of Department/Institute/Center: _____

Punjab University Campus Name: _____

Name of District: _____

INSTRUCTIONS: STUDENTS ARE DIRECTED TO PROVIDE FAIR INFORMATION ESPECIALLY MEDICAL INFORMATION SHOULD BE PROVIDED BY THE MEDICAL DOCTOR.THIS INFORMATION IS HELPFUL FOR THE BENEFIT OF THE STUDENTS IN THE LONG RUN. ANY FAKE OR DISGUISED INFORMATION WOULD BE IDENTIFIED.THE IDENTITY/INFORMATION OF THE STUDENTS WOULD BE KEPT CONFIDENTIAL.

PART-A

BASIC BIO-DATA INFORMATION (TO BE FILLED BY THE STUDENT)

1. Name of the Student: _____

2. Age:_____ 3. Gender: Male / Female 4. Religion: _____

4. Nationality: _____

5.ResidentialAddress: _____

_____

5. Mobile No. of the Student: _____

6. Contact No. of Parent/Guardian: _____

7. Program/Degree: _____ **(MORNING/EVENING/NIGHT)**

8. Semester: _____

9. Session: _____

10.Hostelite or Day scholar: _____

11. If Hostelite: Hostel No._____

Room No._____

PART-B

FAMILY/PERSONAL MEDICAL HISTORY

(TO BE FILLED BY THE STUDENT AND VERIFIED BY THE MEDICAL OFFICER(RMP)

1. Is there any history of any MEDICAL ILLNESS in your family (like: Blood pressure, Diabetes, Tuberculosis(TB),Hepatitis, HIV, Any Allergy, Heart disease etc)

YES: _____ NO:_____

If yes then please specify the type of illness and to whom (mother, father, sibling or others):

_____

2. Is there any history of any PSYCHIATRIC ILLNESS in your family (like: Depression, Anxiety, Schizophrenia etc.) YES: _____ NO:_____

If yes then please specify the type of illness and to whom (mother, father, sibling or others):

_____

3. Is there any history of any SUBSTANCE /DRUG ABUSE in your family (like: Cigarette smoking, alcohol, cocaine etc.) YES: _____ NO:_____

If yes then please specify the type of substance/drug and by whom (mother, father, sibling or others):

_____

4. Do you have any history of any type MEDICAL ILLNESS in past (like: Blood pressure, Diabetes, Tuberculosis(TB),Hepatitis, HIV, Any Allergy, Heart disease etc.)

YES: _____ NO:_____

If yes then please specify the type of illness and for how long:

_____

5. Do you have any history of suffering from any PSYCHIATRIC ILLNESS (like: Depression, Anxiety, stress, Schizophrenia etc.) YES: _____ NO:_____

Please give honest information If yes then please specify the type of illness, at what Age:

_____

Did you get Any treatment/medication for it please specify? _____

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6. Have you noticed any decline in your appetite (during last one month): YES:____ NO:____

7: Have you noticed any loss of weight (during last one month): YES:____NO:___

8: Have you noticed any decline in carrying out your daily routine activities (during past one month): YES:_____ NO:_____

9. Have you noticed any sleep disturbance (during past one month): YES:____ NO:____

10.Have you been indulged in any type of usage of any medication/drug: YES:____ NO:____

If yes then please specify the type of medication or drug you have been using and for how long:

_____

11. Do you have any <u>SURGICAL HISTORY</u> (Like: Any accidental injury, Appendicitis or any other surgical operation etc.) YES: _____ NO:_____

If yes then please specify the type of surgery you have been gone through at what age:

_____

12. Have you been ever indulged in cigarette smoking: YES: _____ NO: _____

PART-C

GENERAL PHYSICAL EXAMINATION (TO BE DONE & FILLED BY THE MEDICAL OFFICER)

1. Overall general physical appearance of the student Fair: ___ Good: _____ Excellent: ____

2. Overall Physical Health of the Student: Below Average: ___ Average:__ Above Average:____

PLEASE FILL IN NUMBERS:

3. Height:_____ ft _____ inches

4. Weight: _____ Kg

5. Blood Pressure:_____ mm/Hg

6. Temperature:_____F

. Pulse rate: _____beats/min

. Respiratory rate: _____ breaths/min

. Any obvious physical disability (Structural abnormal ty on inspection: YES: _____ NO:_____

f YES please specify: _____

.0.Any superficial cuts, needle marks or burn marks on skin: YES: _____ NO: _____

f YES then please specify the nature: _____

(MUST BE VERFIED BY THE RECOGNIZED MEDICAL OFFICER(RMP)

DOCTOR NAME:_____

PMDC NO.: _____

WORKING HOSPITAL/CLINIC ADDRESS:_____

_____

SIGNATURE& STAMP:_____