Questionnaire for Medical Students

(all data will be treated with confidentiality)

Last Name:	First Name:	DOB:
Address:	Zip, City:	
Semester:	Tel.:	

Previous Work with Danger of Infection (including temporary work, civil service, volunteer social year, etc.)

Activities / Workplace	from: to:

Previous Illnesses (especially chronic illnesses and infections, skin diseases, lung diseases, etc.):

Do you currently have health complaints? Yes ☐ No ☐

If yes, which:

Vaccinations	Number	Date/Year of the last vaccine	Year of having had the disease
Rubella			
Measles			
Mumps			
Chicken Pox			

Date

Signature