Medical School Hannover **Anamnesis & Immunization for international visiting students**
Medical Officer

To be filled in by applicant **Please tick the appropriate boxes ☐**

Surname	First name	Date of birth
Street	Maiden name	☐ male ☐ female ☐ diverse
Postal Code, City	Nationality	
Private phone number	Place of birth / country	

Department(s) at MHH	
Which department(s) will you be visiting?	
☐ full-time ☐ part-time hours/week	Shift work ☐ Yes ☐ No
Type of Placement: ☐ Hospitation/visiting student – observation only ☐ Famulatur/internship (Erasmus+) – practical training	
Exposure at the Workplace at MHH	
Do you have to work in front of a computer screen? ☐ No ☐ Yes, an average of _____ hours a day	

☐ Risk of infection	☐ Genetically modified organisms	☐ Heat ☐ Strong heat ☐ Cold
☐ X-ray radiation ☐ Radio-isotopes	☐ Wetness / dampness	☐ Heavy lifting
☐ Wearing a breathing-apparatus	☐ Dust ☐ Welding	☐ Others
☐ Hazardous materials ☐ Yes, which ones?		

Personal History	**Physician's notes:**
Do you suffer from a blood disease? ☐ Yes ☐ No	
Do you suffer from any lung disease? ☐ Yes ☐ No	
Are you prone to bronchial asthma? ☐ Yes ☐ No	
Have you ever had a heart complaint or circulatory problems? ☐ Yes ☐ No	
Have you had a heart attack? ☐ Yes ☐ No	
Do you suffer from high blood pressure? ☐ Yes ☐ No	
Do you have diabetes? ☐ Yes ☐ No	
Did you have a gastric ulcer or duodenal ulcer? ☐ Yes ☐ No	
Have you had jaundice? ☐ Yes ☐ No	
Do you suffer from liver disease? ☐ Yes ☐ No	
Are you prone to skin diseases? ☐ Yes ☐ No	
Do you suffer from allergies? Which ones?	
Do you have a nervous disorder? ☐ Yes ☐ No	
Do you have mental health problems? ☐ Yes ☐ No	
Are you epileptic? Do you have a convulsive disorder? ☐ Yes ☐ No	
Did you have surgery? ☐ No ☐ Yes, when? Which?	
Do you take medication regularly? ☐ Yes ☐ No	
Do you have a disability? ☐ No ☐ Yes, % ☐ applied	
Your height cm and weight kg	

Which children's disease(s) did you have? ☐ Chicken pox ☐ Measles ☐ Mumps ☐ German measles ☐ whooping cough	
Vaccinations ☐ Hepatitis A ☐ Tetanus ☐ Mumps ☐ German measles ☐ Pertussis ☐ Diphtheria ☐ Polio ☐ Measles	

Laboratory results to be filled in by physician

	Date of vaccination:			**Titer : Date and results**
Hepatitis B *	1.	2.	3.	Or minimum titer value (> 100):
Hepatitis C				
Rubella * German measles/Röteln	1.	2.		Or titer:
Measles * Rubella/Masern	1.	2.		Or titer:
Varicella *	1.	2.		Or titer:
HIV				
Covid19	1.	2.		3.
Covid19 Vaccine				
Covid19 Infection	Date of recovery:			
If you come from a non-EU country: Tuberculosis Igra/Quantiferon/ TB-Spot-Test		Quantiferon test negative ☐		Antibodies negative ☐

(* Immunity is required)
Hep B: triple vaccination, last one not older than 10 years is required or a minimum titer value of >100.
Hep C: should be negative

Signed: _____
(Signature of Physician)

Institute / Hospital: _____

Address: _____

Date: _____ Stamp: _____

Please return 4 weeks prior to your arrival in Hannover

postal address: **Medizinische Hochschule Hannover**
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