QUESTIONNAIRE

on the basis of which the competent doctor of family/general medicine issues the Certificate of the Medical and Psychophysical Capabilities to Study Dental Medicine

Name and surname of the applicant: _____

Date of birth (day, month, year): _____ **OIB** (if available)**:** _____

Address of permanent residence (street, house number, postal code, city, country):

_____

E-mail address: _____ **Phone number:** _____

Name of completed secondary school: _____

Study year: _____ **School year:** _____/_____ **City, country:** _____

Name of the university (*for students who have attended university)*:

_____

Academic year: _____/_____ **City, country:** _____

Have you ever had the following diseases (circle either YES or NO):

measles - YES NO, mumps – YES NO, rubella – YES NO, chickenpox - YES NO, paediatric paralysis – YES NO,

whooping cough - YES O, hepatitis B – YES NO, tuberculosis YES NO

Please answer the following questions (mark either YES or NO) and provide an explanation if the answer is YES:

Have you ever had or do you currently have any of the following diseases, conditions, disorders:	YES	NO	If the answer is YES, please explain (diagnosis, stays in hospital, treatment, are you being treated periodically or permanently for this disease, etc.):
Respiratory tract (asthma, obstructive bronchitis, etc.)			
Neurological disorders (epilepsy, febrile convulsions, headaches - recurrent or constant, cerebral paralysis, etc.)			
Gastrointestinal tract, abdominal organs (ulcer disease, hepatitis, ulcerative colitis, etc.)			
Endocrine system (diabetes, thyroid diseases, etc.)			
Heart and vascular diseases (increased arterial pressure, heart defects, rheumatic fever, etc.)			
Musculoskeletal system (bones, joints (scoliosis, kyphosis), etc.)			
Urinary and/or reproductive tract (urinary tract, kidneys, reproductive tract infections, etc.)			
Blood disorders (haematological diseases, anaemia, thrombocytopenia, leukaemia, etc.)			
Psychological disorders			
Skin and subcutaneous tissue (acne, dermatitis, eczemas, allergies, etc.)			
Eye and/or visual system diseases			
Ear and/or hearing diseases			
Tonsils, nose, neck diseases			
Allergies (to food, drugs, plants, animals or any other that have not been mentioned, etc.)			
Major discrepancies in: body height, body weight (including significant weight loss or increase in the last six months), etc.			
Difficulties in verbal communication and speech expression			
Writing and/or reading and/or arithmetic difficulties			

Have you ever been in hospital for treatment? YES NO

If YES, indicate the date, diagnosis and outcome of each treatment:_____

_____

Are you currently taking any medicines or receiving injections (other than those mentioned above)? YES NO

If YES, indicate which, the reason for taking, dose and frequency:_____

_____

Have you ever visited a neurologist, psychologist, psychiatrist or other specialist for neurological, emotional, mental or nutritional issues? YES NO

If YES, explain the reasons and treatment:_____

_____

Have you ever had any restrictions or prohibitions in participation in sports and/or physical education classes? YES NO

If YES, explain the reasons:_____

_____

Please state for which studies the certificate is required, along with the name of the higher education institution (university, college, polytechnic), constituent (faculty, art academy) and attach the certificate form:

_____
_____
_____ .

Along with the completed questionnaire, please attach scanned documents:

1. Vaccination certificate (preschool and school age)
2. Certificate of physical impairment (if applicable)
3. Certificate of appropriate education program (if applicable)
4. Decision to take the state matriculation exam with adjustment of exam technology (if applicable)
5. Medical documentation on previously diagnosed illnesses and health disorders (recent report - if applicable)
6. Study certificate form (downloaded from the website of the higher education institution where the 2026/27 admissions call was announced)

Please note: The competent doctor of family/general medicine has the right to request additional data and medical documentation from the applicant and to perform an examination before issuing the Certificate of Health and Psychophysical Capabilities to Study Dental Medicine.

Place, country: _____

Date: _____
(day/month/year)

Applicant's signature:_____