

**Dr Seeta Raja**

**Private General Practitioner**

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**VACCINE RISK ASSESSMENT FORM** – To be completed by Patient/Parent prior to appointment.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name:  Address: | Weight: | | | |
| Date of birth: | | | |
| Age : | | | |
| E mail: | Telephone number:  Emergency Contact Name and Number: | | | |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | | |
|  | | **YES** | **NO** | **DETAILS** |
| Are you fit and well today | |  |  |  |
| Any allergies including food, latex, medication | |  |  |  |
| Have you, or anyone in your family, had a severe reaction to a vaccine or malaria medication before? | |  |  |  |
| Any other vaccines in the last 1 month? | |  |  |  |
| Tendency to faint with injections | |  |  |  |
| Any surgical operations in the past, including e.g. open heart surgery, spleen or thymus gland removal? | |  |  |  |
| Recent chemotherapy/radiotherapy/organ transplant | |  |  |  |
| Anaemia | |  |  |  |
| Bleeding /clotting disorders (including history of DVT) or on blood thinners? | |  |  |  |
| Heart disease (e.g. angina, high blood pressure) | |  |  |  |
| Diabetes | |  |  |  |
| Additional needs and/or disability | |  |  |  |
| Epilepsy/seizures (or in a first degree relative?) | |  |  |  |
| Gastrointestinal (stomach) complaints | |  |  |  |
| Liver and or kidney problems | |  |  |  |
| HIV/AIDS | |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| Immune system condition e.g. blood cancer |  |  |  |
| Mental health issues (including anxiety, depression) |  |  |  |
| Neurological (nervous system) illness |  |  |  |
| Respiratory (lung) disease |  |  |  |
| Rheumatology (joint) conditions |  |  |  |
| Spleen problems |  |  |  |
| Any other conditions? |  | x |  |
| Are you or your partner pregnant or planning a pregnancy? |  | x |  |
| Are you breast feeding (if applicable) |  | x |  |

|  |
| --- |
| **Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)? |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PLEASE SUPPLY INFORMATION ON ANY VACCINES GIVEN IN THE PAST** **(if known)** | | | | | |
| Tetanus/polio/diphtheria |  | MMR |  | Influenza |  |
| Typhoid |  | Hepatitis A |  | Pneumococcal |  |
| Cholera |  | Hepatitis B |  | Meningitis |  |
| Rabies |  | Japanese encephalitis |  | Tick borne encephalitis |  |
| Yellow fever |  | BCG |  | Other | |
| COVID-19 | | | | | |

Signed by Patient (or Parent/Guardian) ……………………………… Date ………………