

**Dr Seeta Raja**

**Private General Practitioner**

**MBBS Bsc MRCGP DRCOG DFSRH**

**GMC: 7084472**

Jays Pharmacy

Virginia Water, 17 Station Approach, GU25 4DW

Tel- 01344 843169

**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 ………………