

WADESTOWN MEDICAL PRACTICE

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Thank you for providing information about your itinerary and health, so we can give the appropriate vaccinations. Please feel free to ask at your medical appointment if you have any questions at all. Please submit this form to us before arranging your appointment time/date.

Name:

DOB:

NHI (if known):

Itinerary

Date Leaving:

Route travelling (including transit)

Countries visited and duration:

Health History:

Do you have or have you ever had:

1. Any medical problems? *Yes/No*
2. Any medications such as Prednisone, Methotrexate, Biologics such as Humira or other immunosuppressives? *Yes/No*
3. Any leukaemias or lymphomas or immunodeficiency or HIV infection? *Yes/No*
4. Any organ transplants or bone marrow transplant? *Yes/No*
5. Any cancers, chemotherapy or radiotherapy? *Yes/No*
6. Any thymus disorders? *Yes/No*
7. Any allergies? *Yes/No*
8. Specifically egg allergy or a reaction to Yellow Fever vaccine? *Yes/No*
9. A live vaccine in the last 4 weeks? *Yes/No*

Is there any possibility you could be pregnant or are you currently breastfeeding?