|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Personal Details** (to be filled in by **Employee)** | | | | | |
| **Surname:** | | | | **Given Names:** | |
| **Date of Birth:** | | **M**  **F** | | | **Phone Extension:** |
| **Home Address:**  **Post Code:** | | | | | **Home Phone:**  **Mobile:** |
| **Next of Kin/Emergency Contact:** | | **Relationship:** | | | **Contact Number:** |
| **Address:** | | | | | |
| **Medical History** (please complete all details fully) | | | | | |
| **Height:** | **Weight:** | | **Medic Alert:** Yes  No  **Number:** | | |
| **Allergies:** Yes  No | | **If yes, please list:** | | | |
| **Please describe symptoms:** | | | |
| **Current/Regular Medication:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **PAST MEDICAL HISTORY** | | | | | |
| Do you now or have you ever had: (please tick)   |  |  |  |  | | --- | --- | --- | --- | |  | |  |  | | ❑ Diabetes | ❑ Heart murmur | | ❑ Crohn’s disease | | ❑ High blood pressure | ❑ Pneumonia | | ❑ Colitis | | ❑ High cholesterol | ❑ Pulmonary embolism | | ❑ Anemia | | ❑ Hypothyroidism | ❑ Asthma | | ❑ Jaundice | | ❑ Goiter | ❑ Emphysema | | ❑ Hepatitis | | ❑ Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Stroke | | ❑ Stomach or peptic ulcer | | ❑ Leukaemia | ❑ Epilepsy (seizures) | | ❑ Rheumatic fever | | ❑ Psoriasis | ❑ Cataracts | | ❑ Tuberculosis | | ❑ Angina | ❑ Kidney disease | | ❑ HIV/AIDS | | ❑ Heart problems | ❑ Kidney stones | |  | |  |  | | | | Other medical conditions (please list): |  | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |

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| --- | --- | --- | --- | --- |
| **Diseases** | **History of Disease**  **Yes/No/Unknown** | **Vaccination Date** | **Serological Evidence Of Immunity** | |
| Yes/No | Date |
| Hep A |  |  |  |  |
| Hep B |  |  |  |  |
| Varicella  (Chicken Pox) |  |  |  |  |
| Measles |  |  |  |  |
| Mumps |  |  |  |  |
| Rubella |  |  |  |  |
| Influenza  (Annual) |  |  |  |  |
| Pertussis  (Whooping Cough) |  |  |  |  |
| **Tuberculosis (TB)** | | **Yes** | **No** | **Unsure** |
| Have you ever had a positive Mantoux Skin Test? | |  |  |  |
| Have you ever had a positive Quantiferon Gold Assay Blood Test? | |  |  |  |
| Have you ever been treated for TB in the past? | |  |  |  |
| Have you had a BCG vaccination? | |  |  |  |

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| --- |
| **REFUSAL TO PARTICIPATE IN THE EMPLOYEE IMMUNISATION PROGRAM**  I DO NOT wish to participate in the Employee Immunisation Program provided by REDiMED.  I DO NOT wish to undergo and blood testing or receive and treatment and therefore absolve REDiMED of any responsibility in relation to this matter.  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FOR NURSING USE ONLY:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Investigation | REQUEST ACTIONED | **Date** | **RESULT** | Comment |
| Hep A |  |  |  |  |
| Hep B |  |  |  |  |
| Varicella |  |  |  |  |
| Measles |  |  |  |  |
| Mumps |  |  |  |  |
| Rubella |  |  |  |  |
| Pertussis |  |  |  |  |
| Influenza |  |  |  |  |