**VACCINATION REGISRATION FORM FOR HEPATITIS B**

NAME:

AGE:

GENDER: MALE/FEMALE/OTHERS

IF YOU ARE FEMALE, ARE YOU PREGNANT OR BREAST FEEDING CURRENTLY? YES/NO

HAVE YOU SUFFERED FROM HEPATITIS IN THE PAST: YES/NO

IF YES, ARE YOU CURRENTLY SUFFERING FROM HEPATITIS: ACUTE HEPATITIS/CHRONIC HEPATITIS

HOW DID YOU GET INFECTED?

* BY BIRTH
* BLOOD DONATION/TRANSFUSION
* SHARING OF INFECTED MATERIAL LIKE RAZORS, TOOTHBRUSH, INJECTION ETC
* NEEDLESTICK INJURY

HAVE YOU RECEIVED BLOOD TRANFUSION IN THE PAST? YES/NO

DOES ANYONE IN THE FAMILY SUFFER FROM HEPATITIS B? YES/NO

DOES YOUR PROFESSION ENTAIL EXPOSURE TO INFECTED MATERIAL LIKE NEEDLES/SYRINGES/DRUG INJECTION? YES/NO

DO YOU INTEDN TO TRAVEL TO PLACES WHERE HEPATITIS B IS ENDEMIC? YES/NO

ARE YOU SUFFERING FROM SEXUALLY TRANSMITTED DISEASE? YES/NO

ARE YOU SUFFERING FROM DISEASES LIKE CRONIC KIDNEY/LIVER DISEASE, HIV INFECTION, HEPATITIS C? YES/NO

DO HAVE HISTORY OF ANY ALLERGY? YES/NO

VACCINATION SCHEDULE

|  |  |  |  |
| --- | --- | --- | --- |
|  | FIRST DOSE | SECOND DOSE | THIRD DOSE |
| DATE OF VACCINATION |  |  |  |
| GIVEN BY |  |  |  |
| PLACE OF VACCINATION |  |  |  |