

# Health Assessment Questionnaire

[Company Name]

Surname:		Prof <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/>
Forename(s):		Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="checkbox"/>
Work Address/Place of Study:		
Tel:	Mobile:	Email:
Date of birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	

## VACCINATION HISTORY

Please give details of vaccinations and tests you have had. Where possible, give dates and results.

Immunisation History		
1a	MMR vaccination	Dates: 1 <sup>st</sup> 2 <sup>nd</sup>
1b	Measles, mumps and rubella blood test	Date: Result:
2a	Hepatitis B vaccinations	Date: (1) Date: (2) Date: (3)
2b	Hepatitis B booster	Date:
2c	Hepatitis B antibody screening	Date: Result:
3a	Heaf, Mantoux or Tine test (TB test)	Date:
3b	BCG (TB vaccination)	Date:
4	Polio booster	Date:
5	Tetanus booster	Date:
6	Have you had chicken pox?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
6a	Varicella (chickenpox) blood test	Date: Result:
	Varicella immunisations	Dates: 1 <sup>st</sup> 2 <sup>nd</sup>
7	Other (specify)	Date: