



# Yellow Fever Questionnaire

**Puddletown Surgery**  
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Name:	Address:	
Date of Birth:	Tel No:	Destination Date Duration
Usual GP:	Surgery:	

Please give details of all medical problems you have, or have had including operations and dates where possible

Details	Date

Are you currently taking Steroids <i>(Prednisolone for example)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you currently receiving treatment for cancer, or any other treatment that might compromise your immune system? <i>(Chemotherapy, or radiotherapy for example)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any chance you might be pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you allergic to eggs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you allergic to neomycin or polymixin?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you allergic to any other medication <i>(If yes, please give details)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you HIV positive?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you currently well?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I consent to the vaccination

(Signature)

(Date)