WORLDWISE® Travellers Health & Vaccination Centres

AUCKLAND, HAMILTON, NEW PLYMOUTH, PALMERSTON NORTH, CHRISTCHURCH, NELSON

CANADIAN IMMIGRATION PATIENT INFORMATION DETAILS

Date:

Family Name:	**First Name:**	**IME/ UCI Number:**
Address:	**Date of Birth:**	**Male / Female**

Are you a New Zealand Citizen ☐ Resident ☐ | **NHI Number:**

Contact email address:

Contact Phone Number: (Home) **(Work)** **(Mobile)**

Occupation: | **Company Name:**

General Practitioner (Name and Address)

Next of Kin: (Name and Contact Phone Number)

YOUR HEALTH- Please circle (provide additional information if circled 'yes' below)

1.	Tuberculosis (TB), treatment for tuberculosis?	Yes	No
2.	Close household or work contact with Tuberculosis?	Yes	No
3.	Prolonged medical treatment and/or repeated hospital admissions for any reason, including major operation or psychiatric illness?	Yes	No
4.	Psychological/Psychiatric Disorder (including major depression, bipolar disorder or schizophrenia)?	Yes	No
5.	An abnormal or reactive HIV blood test?	Yes	No
6.	Hepatitis B or Hepatitis C blood test?	Yes	No
7.	Cancer or malignancy in the last 5 years?	Yes	No
8.	Diabetes?	Yes	No
9.	Heart condition including coronary disease, hypertension, valve or congenital disease?	Yes	No
10.	Blood Condition (including thalassemia)?	Yes	No
11.	Kidney or Bladder disease?	Yes	No
12.	An ongoing physical or intellectual disability affecting your current or future ability to function independently or be able to work full-time (including autism or developmental delay)?	Yes	No
13.	An addiction to drugs or alcohol?	Yes	No
14.	Are you taking any prescribed pills or medication (excluding oral contraceptives, over-the-counter medication and natural supplements)?	Yes	No
15.	FOR FEMALE CLIENTS:		
	a) Are you pregnant?	Yes	No
	b) If yes, what is the expected date of delivery?	/ /	
	c) Do you wish to proceed with the required x-ray examination?	Yes	No

Additional information for 'Yes' response only:

FAMILY HISTORY:

SOCIAL HISTORY:
Smoking amount per week:
Alcohol consumption per week:

Informed consent: I acknowledge that the information given above is truthful. I accept all information given will be kept confidential, and will not be released without my authority. I realise that I may be given vaccinations and understand what they are for, and side effects that may be expected from them. I consent to having these vaccinations. I understand that above information may be used for research use. In the event of non-payment of monies owing by me, WORLDWISE reserves the right to pass on to me all charges related to debt collection.

Please circle, then sign. SELF / PARENT / CAREGIVER(GUARDIAN) ***Signature:*** ....

FOR DOCTOR / NURSE TO FILL OUT

PHYSICAL EVALUATION:

Height: ………………………cms

Weight ………………………kgs

Blood pressure: …………………../…………………

Pulse rate: …………………min………………charact.

Urine ……………..glucose………………..protein…………..blood

Eyes:

Left	Right	Both (Aided / Unaided)

CLINICAL NOTES

DATE	NOTES