



Breakspear Hospital

ADULT Medical Questionnaire and Consent Form for BCG & Skin Test

Please complete all the white boxes.

Date of first appointment (dd/mm/yyyy)

First name Surname

Male Female Date of birth (dd/mm/yyyy)

Address

Post code

Contact number Alternative

GP name

GP address Post code

GP contact number

Medical history:

1. Have you ever had a vaccination against Tuberculosis (BCG) or a recent skin test? Yes No
2. In the last 3 months, have you received a high dose of steroid therapy or any other immunosuppressant medication? Yes No
3. Have you been treated for leukaemia or malignant disease? Yes No
4. Is there any known HIV infection? Yes No
5. Have you ever been treated for tuberculosis or currently receiving TB treatment? Yes No
6. In the last 3 weeks, have you had a severe viral infection? Yes No
7. In the last 3 months, have you had any infection needing antibiotics? Yes No
8. In the last 3 months, have you had any injection or blood transfusion? Yes No
9. Have you ever had an adverse reaction to any immunisation? Yes No
10. Are you suffering from a generalised skin infection or infected eczema? Yes No
11. Do you have any known allergies to the vaccine components? Yes No
12. Have you had any known contact with TB? Yes No
13. Do you have any other medical conditions? Yes No

If yes, please explain.

14. Women only — Date of last menstrual cycle (dd/mm/yy):

*Vaccination will be postponed if your temperature is above 37.3 °C at consultation.
BCG is not to be given during pregnancy.*

I (full name) _____ hereby consent to receive a skin test and a BCG immunisation or referral to a chest clinic, whichever proves necessary.

Signature _____

Date _____

HOSPITAL USE ONLY

BCG Vaccination

Date	<input type="text"/>	Temperature	<input type="text"/>
Medical conditions	<input type="text"/>	Injection site	<input type="text"/>
General Health on day of vaccination	<input type="text"/>	Batch number	<input type="text"/>
Vaccine	<input type="text"/>	Dose	<input type="text"/>
Doctor's signature	<input type="text"/>	Exp date	<input type="text"/>
		Make	<input type="text"/>
		Nurse's signature	<input type="text"/>

Mantoux Skin Test

Patient's name	<input type="text"/>	Temperature	<input type="text"/>
Batch number	<input type="text"/>	Date & time of skin test	<input type="text"/>
Manufacturer	<input type="text"/>	Exp date	<input type="text"/>
Injection site	<input type="text"/>	Dose & strength administered	<input type="text"/>
Date to be read	<input type="text"/>	Date and time test read	<input type="text"/>
Results in mm	<input type="text"/>		
Adverse reactions	<input type="text"/>		
Any blistering present	<input type="text"/>		
Any ulceration present	<input type="text"/>		
BCG required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Referral required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Doctor's signature	<input type="text"/>	Nurse's signature	<input type="text"/>

Notes