WORLDWISE®
Travellers Health & Vaccination Centres

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

NEW ZEALAND IMMIGRATION PATIENT INFORMATION DETAILS

Date:		
Family Name:	**First Name:**	**NZER Number:**
Address:	**Date of Birth:**	**Male / Female**
Visa Category: ☐ **Temporary**	☐ **Residence**	☐ **Work to Residence**
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:

Left	Right	Both (Aided / Unaided)

Eyes: (see above)

Height: ………………………cms

Weight ………………………kgs

Blood pressure: …………………./…………………

Pulse rate: ………………….min……………….charact.

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

CLINICAL NOTES

DATE	NOTES