Dengvaxia Questionnaire – First Dose

**Date of Enrolment**: \_\_\_\_\_\_\_\_\_\_\_ **Nurse or Doctor Enrolling Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Patient DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Contact Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Q1. Which clinic did you visit?**

 ( ) Brisbane ( ) Adelaide ( ) Perth ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q2. Gender (Please Circle):** Male Female

**Q3. Are you between 18 and 60 years of age? (Please Circle):** Yes No
If NO, you may be ineligible for the vaccine. Please discuss this with your doctor or nurse.

**Q4. Over the next three years, will you be spending a cumulative total of three (3) months in tropical areas of Asia, the Pacific Islands, Central America, or Africa?**

YES NO

**Q5. Which regions or countries are you planning on travelling to in the next three years**?

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**Q6. What are your usual travel patterns in regards to places, reasons, duration and frequency?** i.e. FIFO worker going to PNG for one month on, one month off; a VFR travelling to India every year for 1-2 months; consultant who travels to the Pacific Islands every 1-2 months.

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**Q7. Do you have a past history of Dengue which has been confirmed with a blood test?** YES NO ( if no you are not eligible to participate )

**Q8. In what year(s) did you have Dengue Fever?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q9. Which country or countries were you infected**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q10. How many DAYS were you off work and/or usual daily activities when you had dengue**?

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**Q12. Do you currently have any of the following medical conditions**? If YES, to any question, you may be ineligible. Please discuss with your nurse or doctor.

**Q13.** **Do you currently have any of the following medical conditions?** If YES to any of these questions, you may be ineligible to participate. Please discuss the doctor or nurse before proceeding.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please TICK** | **YES** | **NO** | **Please TICK** | **YES** | **NO** |
| Diabetes |  |  | Long Term Antibiotics |  |  |
| Heart Problems |  |  | Depression |  |  |
| Asthma |  |  | Kidney Dysfunction |  |  |
| Epilepsy |  |  | Digestive/stomach issues requiring medication |  |  |

**Q14. Please list any medication (including over the counter, or herbal medications) that you take regularly**. If no medications, please write NIL.

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**Q15. Please confirm that you are receiving the FIRST dose of dengue fever vaccine today**.

YES, I am. 

**Q16. Did you receive any other vaccines today**? If YES, please list below.

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**Q17. Do you consent to being contacted by telephone in ten days’ time to determine if you have developed any side effects from the vaccine**?

Sign and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q18. Do you have any further comments or questions**?

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Thank you for participating!