Q FEVER PRE-SCREENING QUESTIONNAIRE

PERSONAL DETAILS

Family name:		Given names:	
Date of birth: ___ / ___ / ___	Sex: M / F	Home phone: ( )	Mobile:

PREVIOUS DIAGNOSIS

Have you ever been diagnosed with Q Fever?	YES / NO
If **YES,** when? ____________	Doctor's Name:
Doctor's address:	
Please complete the Q Fever Release of Information Authority to allow us to check your medical records.	

SCREENING AND VACCINATION

Have your ever participated in a Q Fever vaccination screening and vaccination program?		YES / NO
If YES: When:	Where:	
Have you ever been vaccinated for Q Fever?		YES / NO
If YES: When:	Where:	
If YES to either question please complete the Q Fever Release of Information Authority to allow us to check your medical records.		

RISK FACTORS

Have you ever lived on a sheep, cattle, goat or dairy property?	YES / NO
If YES, length of time:	
Have you ever regularly visited a sheep, goat, beef or dairy cattle property?	YES / NO
Do you or have you worked in the meat processing industry?	YES / NO
If YES, for how long?	

Tick the activities you do currently or have done in the past:

☐ Feedlot work	☐ Shearing	☐ Collecting sheep / cattle manure for the garden
☐ Stock / farm work	☐ Milking cows or goats	☐ Birthing sheep, cattle or goats
☐ Tannery work	☐ Livestock trading	☐ Private slaughter of sheep, cattle or goats
☐ Animal transport	☐ Dog or cat breeding	☐ Dressing kangaroo carcasses or skins
		☐ Other associated activities of livestock production

ILLNESS and OTHER CONDITIONS

Do you recall having an illness, possibly lasting 7 days or more that included symptoms such as fever, chills, sweating, muscle and joint pains, severe headache and fatigue?		YES / NO
If YES, when:	Were you absent from work?	YES / NO
Do you have any allergies, particularly to eggs?		YES / NO
Have you ever had any other reactions to vaccines?		YES / NO
Do you have cancer of the blood, lymph nodes or bone marrow?		YES / NO
Are you currently being treated with:		
Cortisone or other corticosteroids?		YES / NO
Any form of cancer medication or radiation?		YES / NO
Other medications?		YES / NO
Females: Are you pregnant or is there any risk of pregnancy?		YES / NO

This information given here forms part of your confidential medical record – it can only be accessed with your express permission.