Health Assessment Form for Migrants

Private and Confidential

Affix ID Label Here

General

What is your place of birth? _____

What is your ethnic or cultural background?

White:	Irish	☐
	Irish Traveller	☐
	Any other white background	☐
Black or Black Irish:	African	☐
	Any other black background	☐
Asian or Asian Irish	Chinese	☐
	Any other Asian	☐
Other including mixed background: (describe)	_____	

Date Last Travelled Abroad ☐☐/☐☐/☐☐☐☐

Primary Language _____

Interpreter required **Yes** ☐ **No** ☐

Reason for Attending

Existing Medical Conditions

Medications

Allergies

Family History

Affix ID Label Here

Conditions around migration

Current circumstances in Ireland

How long have you been in Ireland? _____

Living Arrangements? _____

Where do you live? _____

_____

With whom do you live? _____

_____

How many people are in the household? _____

Reason for migration?

- Study ☐
- Work ☐
- Forced ☐
- Asylum ☐
- Other _____

_____

Previous circumstances in country of origin

Socio-economic group/ occupation _____

Other relevant information e.g. torture, rape _____

_____

Experience during migration process (optional)

	Hours	Days	Weeks	Months
Length of time to get to Ireland from country of origin	☐	☐	☐	☐

Other comments

Affix ID Label Here

Infectious Disease Assessment

Tuberculosis

	Yes	No
Have you ever been told you have had TB?	☐	☐
Have you ever taken medicine to treat or prevent TB?	☐	☐
Have you ever been in contact with a person sick with TB?	☐	☐
Have you had a persistent cough for more than two weeks?	☐	☐
Do you cough up phlegm or blood?	☐	☐
Have you lost weight recently?	☐	☐
Do you sweat more than usual at night?	☐	☐

Bloodborne viruses

Hepatitis

	Yes	No
Have you ever been diagnosed with viral hepatitis?	☐	☐

If yes, which type? **A** ☐ **B** ☐ **C** ☐ **E** ☐

HIV

	Yes	No
Have you ever been diagnosed with HIV?	☐	☐
If yes, when: _____		
Are you on treatment for HIV?	☐	☐

Childhood Infectious Diseases

	Yes	No
Measles	☐	☐
Mumps	☐	☐
Rubella	☐	☐
Chickenpox	☐	☐

Other

	Yes	No
Have you ever had malaria?	☐	☐
If yes, when: _____		
Were you treated for malaria?	☐	☐
Have you ever been diagnosed with a parasite infection such as schistosomiasis, strongyloides?	☐	☐
If yes, when: _____		
Did you receive treatment?	☐	☐

Sexual History

	Yes	No
Are you currently sexually active?	☐	☐
If yes, when was the last time you had sex? _____		

Do you have sex with: **Men** ☐ **Women** ☐ **Both** ☐

Have you noticed any symptoms such as:

	Yes	No
1. Pain on urination	☐	☐
2. Penile/vaginal discharge	☐	☐
3. Abdominal/pelvic pain	☐	☐
4. Ulceration on the genital area	☐	☐

Affix ID Label Here

Immunisation history

	Yes	No/unknown	No. of doses received	Date of last dose
BCG	☐	☐		
Measles	☐	☐		
Mumps	☐	☐		
Rubella	☐	☐		
Diphtheria	☐	☐		
Tetanus	☐	☐		
Pertussis	☐	☐		
Polio	☐	☐		
Haemophilus Influenzae (B)	☐	☐		
Chickenpox/varicella	☐	☐		
Hepatitis A	☐	☐		
Hepatitis B	☐	☐		
Meningococcal C	☐	☐		
Pneumococcal	☐	☐		
Human papilloma virus	☐	☐		

Record of investigations and results

	Test requested Yes	Test requested No	Result Pos	Result Neg
TB				
Mantoux	☐	☐	_____	
IGRA	☐	☐	_____	
CXR	☐	☐	_____	
Hepatitis B			**Pos**	**Neg**
HBsAg	☐	☐	☐	☐
Anti-HBs	☐	☐	☐	☐
Anti-HBc	☐	☐	☐	☐
HBeAg	☐	☐	☐	☐
Anti-HBe	☐	☐	☐	☐
Hepatitis C				
Anti-Hep C	☐	☐	☐	☐
HCV Antigen	☐	☐	☐	☐
HCV RNA	☐	☐	☐	☐
HIV Ab/Ag	☐	☐	☐	☐
Other (name)	_____			
Women of Childbearing Age				
Rubella	☐	☐	**Immune** ☐	**Non-immune** ☐
Varicella	☐	☐	**Immune** ☐	**Non-immune** ☐
Pregnancy	☐	☐	**Pos** ☐	**Neg** ☐

Record of vaccines administered

Name of vaccine	Batch no.	Manufacturer	Site used	Dose administered	Date given	Dose no.	Date next dose due	Signature

Specialist referrals requested after consultation (please indicate which specialty)