Hamilton East Medical Centre

THE TRAVEL DOCTOR TMVC TRAVELLER'S MEDICAL & VACCINATION CENTRE

Travel Questionnaire

You

First Name ______ Last Name ______ Age ______

Date of Birth ______ Sex ☐ M / ☐ F Email ______

Ethnicity ______ Country of Birth ______

Current Address ______

Suburb/City ______ Country ______

Permanent Address *(if different from above)* ______

Suburb/City ______ Country ______

Phone No: Home: ______ Work: ______ Mobile: ______

Occupation ______ Company/Organisation ______

GP Name & Suburb Notes to be sent to GP ☐ Yes | ☐No

NOK Contact Person ______ NOK Phone Number ______

NOK Address ______ NOK Relationship ______

Your Health

1	Have you travelled to less developed countries before *Did you have health problems while away?* ______	☐ Yes	☐No	1
2	Do you have or have you ever had any medical problems? e.g. blood clots, asthma, chest problems, heart disease, high blood pressure, diabetes, stomach ulcer, psoriasis, joint problems, cancer mastectomy, splenectomy, epilepsy, depression, schizophrenia, anxiety attacks, mental illness, weakness of the immune system, HIV/AIDS, thymus disorders? *If yes, please specify* ______	☐ Yes	☐No	2
3	Do you have a family history of blood clots, depression, schizophrenia, anxiety attacks or mental illness? *If yes, please specify* ______	☐ Yes	☐No	3
4	Are you taking an regular medication (both prescription & non-prescription) e.g. the contraceptive pill, vitamins or do you occasionally take medication e.g. migraine tablets, Ventolin? *Name of all medications* ______	☐ Yes	☐No	6
5	Are you allergic to anything? e.g. sulphur drugs, penicillin, tetracycline's, neomycin, mercury/thiomersal, gelatine, eggs, iodine, latex, Band-Aids, insect bites? *If yes, please specify* ______	☐ Yes	☐No	7
6	Have you been in hospital, been ill or injured in the last six weeks?	☐ Yes	☐No	4
7	Have you had immune globulin or a blood transfusion in the last twelve (12) months	☐ Yes	☐No	5
8	Have you ever felt faint or fainted after an injection or giving blood?	☐ Yes	☐No	8
9	Woman Only: Are you pregnant or planning to become pregnant while travelling or within three (3) months of your return?	☐ Yes	☐No	9
10	Did you miss any of the usual childhood vaccines?	☐ Yes	☐No	10
11	Do you have any particular health concerns regarding this trip?	☐ Yes	☐No	11

Your Trip

12 Please list in order the countries you intend visiting, and how long (in weeks) you plan to spend in each:

i.	________	( )	weeks	Drs Use only
ii.	________	( )	weeks	________
iii.	________	( )	weeks	________
iv.	________	( )	weeks	________
v.	________	( )	weeks	________
vi.	________	( )	weeks	________
vii.	________	( )	weeks	________
viii.	________	( )	weeks	________

13 What is the main purpose of your trip?

☐ Holiday ☐ Visiting family/friends ☐ Business Trip ☐ Other

14 Type of accommodation?

☐ Camping ☐ Budget ☐ Air-conditioned hotel ☐ Private Home ☐ Other

15 Planned activities

☐ Trekking/Altitude ☐ Scuba Diving ☐ Cycling ☐ Rafting/Boating ☐ Other

16 Date leaving this city? ________

17 Date leaving New Zealand ________

18 Return date to New Zealand ________

19 Place of departure from New Zealand ________

Other

20 How did you learn of this Travel Doctor?

☐ Travel Agent (which one?) ________

☐ Publication (which one?) ________

☐ Doctor (please name) ________

☐ Website (please specify) ________

☐ Workplace (please specify) ________

☐ Friend ☐ Other

21 How will you be paying for your visit today?

☐ EFTPOS ☐ Cash ☐ Credit Card ☐ Company Account

Signature: ________ Date: ________

Thank you!

First Name ____________ **Last Name** ____________ **Age** ______

CLINIC USE ONLY

Date:		**Visit 1**	**Visit 2**	**Visit 3**	**Visit 4**	**Visit 5**
Disease / PHx / Vaccine						
Polio						
Tet/Dip/DTaP						
MMR						
Varicella						
Flu						
Pneumonia						
Typhoid						
Hep A						
Hep A / Typhoid						
Hep B						
Hep A / Hep B						
Meningitis (ACWY)						
Yellow Fever						
Cholera						
Jap. Enceph.						
Rabies ID IM						
BCG (Scar/No Scar)						
Mantoux / Quantaferon Gold						
RN signature						
Malaria Chemoprophylaxis / Doxy / Lariam / Malarone / Chloroquine						
Medical Kit						

Advice Check List

☐	Food / Water	☐	Insect avoidance
☐	DVT risk / prevention	☐	Woman's health
☐	Sexual health	☐	Personal safety / insurance
☐	Drug interactions	☐	Activity advice – Altitude
☐	Activity advice – Diving	☐	Activity advice – Cycling
☐	Activity advice – Rafting / Water	☐	Activity advice –Other
☐	Yellow book	☐	Section 29
☐	Well Child book copied	☐	IHG

Doctors signature ____________________