

PRE-TRAVEL QUESTIONNAIRE FORM

Please bring **COMPLETED QUESTIONNAIRE, TRAVEL ITINERARY** and any **VACCINE RECORDS** with you to your appointment.

SECTION A TRAVELER INFORMATION

First Name: _____ Last name: _____

Date of Birth: ___/___/___ Age: _____ Gender: M / F Email address: _____

Home Address: _____ Primary Phone: _____

Doctor: _____ Medical Centre _____ Phone: _____

SECTION B TRAVEL ITINERARY

Departure Date: _____ / _____ / _____ Return Date: _____ / _____ / _____

Countries To Be Visited (In Order)	City or Region	Length of Stay (Days)
1.		
2.		
3.		
4		

Accommodations: Hotel Hostel Family Home Cruise Camping Other _____

Purpose of Trip: Holiday Business Visiting family/friends School trip Other _____

Activities planned: Diving/Snorkelling Fresh water/Rafting Trekking Cycling Altitude

Do you have any concerns over this trip? _____

SECTION C MEDICAL HISTORY

Health Conditions:

Heart Blood Pressure Cholesterol Blood clots Blood thinners Seizures Thymus/splenectomy

Organ/bone marrow transplant Skin condition Cancer Lung problems/Asthma Diabetes Joint problems

Stomach ulcers Epilepsy Weak Immune system HIV/AIDS Mental illness Panic attacks

Recent hospitalisation/ illness/ injury in the last 6 months? _____

Are you currently undergoing any medical treatment? _____

Allergies: Any medications Eggs Gelatine Iodine Latex Insect bites Other _____

Current Medications: _____

Women only: Are you **PREGNANT?** Or trying to become pregnant/ nursing or within 3 months of your return? Yes/No

SECTION D IMMUNIZATION HISTORY & PLAN

Have you had all your childhood vaccines? Yes/No (circle)

Have you had any Previous Travel vaccines? _____

Advice Checklist

Food/water Insect avoidance Yellow Fever Rabies Altitude DVT Schistosomiasis

Activity advice Personal safety/Insurance Drug interactions Sexual health Section 29

Recommended Vaccines

Vaccines			Vaccines		
Influenza (Flu)	\$36		Hep A	\$100	
Tetanus/Diphtheria/Pertussis	\$62		Hep A Jnr	\$67	
			Hep A/Typhoid	\$160	
Diphtheria/Tetanus/Pertussis/Polio	\$97		Hep B	\$55	
Typhoid Injection	\$90		Hep A/B	\$100	
Typhoid capsules (3 capsules)	\$70		Hep A/B Jnr	\$70	
Rabies	\$148		Polio	\$87	
Yellow Fever	\$126		Meningococcal	\$140	
Japanese Encephalitis	\$250		Cholera	\$65	
Malaria Adult	\$10/tab		Malaria Jnr	\$5/tab	

YELLOW FEVER – have you read the CDC Yellow Fever vaccine information sheet yes no

SECTION E PATIENT CONSENT

1. Are you currently sick or experiencing a high fever? Yes/No
2. Have you had any allergies or had a serious reaction to a vaccine in the past? Yes/No
3. Do you have any medical problems that makes it hard for you to fight infection? Yes/No
4. Have you recently had any other vaccination or blood products? Yes/No
5. Are you pregnant or thinking of becoming pregnant within the next 3 months? Yes/No
6. Are there any other concerns? Yes/No

I have been fully informed regarding the requested vaccination/s and I have had a chance to ask questions.

I understand the benefits and risks of the vaccination/s, and request the vaccination be given to me, or the person named below for whom I am authorised to make this request.

I consent for the inclusion of this immunization data in the NIR (National Immunisation Register).

Signature of Patient/Parent or Guardian

Witnesses

Date

The person being vaccinated agrees to remain in the building for 20 minutes after receiving the vaccination. Possible side effects include discomfort, aching, redness or lump at injection site. In rare severe cases the person receiving the vaccination may have a severe reaction and require medical intervention