PRE-TRAVEL MEDICAL QUESTIONNAIRE

Name: _____ D.O.B: ____/____/_____

PART A: Details of the Trip

Departure Date: ____/____/_____ Total Length of Trip: _____

I will be visiting the following places:

Town	Country	Urban/rural	Accommodation	No. days	Special considerations	Type of trip (bus/tour/backpack/cruise)

Will you be undertaking any special adventure activities? (please circle)

Scuba Diving / Cycling / Cave Exploration / Trekking / Mountain Climbing / Safari
Other (please specify): _____

PART B: Vaccination Record

Did you miss any of your childhood vaccines? YES / NO
Have you had the following vaccines? (Please Tick)

Vaccine	Yes	No	Year	Vaccine	Yes	No	Year
Tetanus/Diphtheria				Pneumonia			
Measles/Mumps/Rubella				Meningitis			
Polio				Yellow Fever			
Hepatitis A				Rabies			
Hepatitis B				Typhoid – oral			
Influenza				Typhoid – injection			
				Other			

PART C: Health Issues Which May Affect Your Travel or Vaccinations

1. Have you had any health problems on previous trips overseas? YES / NO

If you are a regular patient at our clinic and we hold up to date information about you, please skip to question 8.

2. Do you have or have you had any of the following medical problems? (Please Tick)

MEDICAL CONDITION	Yes	No	MEDICAL CONDITION	Yes	No
Heart Disease			Hepatitis A		
Irregular Heart Beat			Thymus Disease		
High Blood Pressure			Bleeding Disorders		
Respiratory Problems			HIV/Aids		
Asthma			Splenectomy		
Diabetes			Cancer		
Epilepsy			Depression/Anxiety		
Stomach Ulcer			Psychiatric problems		
Psoriasis			Inflammatory Bowel Disease		

Other please specify: _____

3. List any major surgery you have had e.g.: open heart surgery:

_____
_____
_____
_____

4. Have you had any illness or injury in the last 6 weeks requiring medical attention? Yes / No

5. Have you recently undergone radiotherapy, chemotherapy or steroid treatment? Yes / No

6. List all your current medications including oral contraceptive:

_____
_____
_____

7. Are you allergic to: medication / food / eggs / other ? (please circle)
   If yes, please specify: _____

8. Have you ever felt faint or fainted after having an injection? Yes / No

9. Have you had a serious reaction to a vaccine in the past? Yes / No
   If so, which vaccine was it? _____

10. Have you had any of the following vaccines in the past 3 weeks -
    Yellow Fever, BCG, MMR, Varicella? Yes / No

11. Do you have any health concerns regarding this trip? Yes / No
    If yes, please outline: _____

For Women:

12. Are you pregnant, planning a pregnancy within the next 3 months, or breast feeding? Yes / No

Thank you for completing this form.
Please provide this completed document to your doctor at the time of your consultation.