Travel Questionnaire

I M P O R T A N T  
It is preferable that your travel consultation appointment is made one month prior to your departure. Please return this form promptly. You will be advised of an appointment time and date.

P L E A S E N O T E  
There will be a charge for each person, even if your travel has been discussed previously with your own GP.

**TRAVELLER'S MEDICAL RECORD**

|  |  |
| --- | --- |
| DATE: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| FIRST NAME: |  | SURNAME: |  |

|  |
| --- |
| ADDRESS: |
|  |

|  |  |
| --- | --- |
| POST CODE: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| DATE OF BIRTH: |  | ETHNICITY: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| TELEPHONE: |  | MOBILE PHONE: |  |

|  |  |  |
| --- | --- | --- |
| I (FULL NAME) |  | hereby consent to |
| the administration to myself of the vaccines as listed below. | | |

**YOUR HEALTH**

1. Have you travelled to less developed countries before? *Yes / No*

Did you have any health problems while away? *Yes / No*

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| --- | --- |
| If yes, please specify : |  |

1. Do you have or have you ever had any medical problems? For example, asthma, blood clots, cancers, chronic bronchitis, anxiety attacks or depression, diabetes, epilepsy, heart disease, HIV/AIDs, mental illness, stomach ulcer, splenectomy, schizophrenia, weakness of immune system.

*Yes / No*

|  |  |
| --- | --- |
| If yes, please specify : |  |

1. Have you been in hospital in the last year? *Yes / No*
2. Have you had a blood transfusion? *Yes / No*
3. Have you ever had hepatitis? *Yes / No*
4. Are you taking any medication now? For example: contraceptive pill, antibiotics or do you occasionally take medication? For example: migraine tablets, Ventolin, vitamins. *Yes / No*

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| --- | --- |
| If yes, please specify : |  |

1. Do you have any known allergies? For example: sulphur drugs, eggs, nuts, penicillin, bee stings, iodine, neomycin, latex, band aids? *Yes / No*

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| --- | --- |
| If yes, please specify : |  |

1. Women: Are you pregnant or is it a possibility on your return? *Yes / No*
2. Please list any past vaccinations and date/year of administration:

BCG Diphtheria/Tetanus Typhoid Hep A Hep B

Meningitis Influenza MMR Rabies Polio Yellow Fever

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| --- | --- |
| Other: |  |

1. Do you have any particular health concerns regarding this trip? *Yes / No*

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| --- | --- |
| Please outline: |  |

**YOUR TRIP**

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

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | days |
|  |  |  | days |
|  |  |  | days |
|  |  |  | days |
|  |  |  | days |
|  |  |  | days |
|  |  |  | days |

What is the main purpose of your trip? (Please circle)

Holiday Visiting family/friends Business Trip

|  |  |
| --- | --- |
| Other: |  |

Type of accommodation? (Please circle)

Camping Budget Air conditioned hotel Private Home

|  |  |
| --- | --- |
| Other: |  |

Planned activities? (Please circle)

Trekking / Altitude Scuba Diving Cycling Rafting / Boating

|  |  |
| --- | --- |
| Other: |  |

|  |  |
| --- | --- |
| Date leaving New Zealand: |  |
| Date returning to New Zealand: |  |

**PRE-TRAVEL WORKSHEET** (to be discussed with Medical Staff)

Vaccine: Number of doses required. Please tick the vaccinations you wish to have.

1. Hepatitis A: One injection, booster at 12 months will provide immunity up to 10 years.
2. Hepatitis A & B: Course of three injections. 0, 1 and 6 months.
3. Hepatitis B: Course of three injections one month apart. Lifelong immunity.
4. Japanese Encephalitis: Two injections. 1, 28 days after first injection.
5. Meningococcal ACYW135 (Menectra): One injection. Booster at 3 years.
6. Polio: One injection if had childhood immunisation. Booster every 10 years.
7. Rabies: Three injections. 0, 7, 28 days. Booster at one year.
8. Tetanus: One injection if more than 10 years since previous booster dose.
9. Typhoid: One injection OR 3 capsules taken on Day 1, day 3 and day 5 -Three yearly booster.
10. Hepatitis A / Typhoid Booster six months: Revaccinate against typhoid every three years.
11. Cholera: Two sachets taken 1 week apart - booster if needed at 2 years.
12. Yellow Fever: One injection - lifelong immunity.

|  |  |
| --- | --- |
| 1. Other: e.g. Influenza, pneumococcal, tick borne encephalitis: |  |
|  | |

**RECOMMENDED MALARIA PROPHYLAXIS / ORAL MEDS:**

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I have been informed of the following:

* The vaccines being given today.
* The care after vaccination.
* The risks of vaccination.
* The possible side effects.
* The procedure to follow in the case of an adverse event.

I am satisfied that I have received enough information today explaining both the benefits and risks of the vaccines to be administered. Any questions I had have been answered to my satisfaction. I have been informed about the immunisation.

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| --- | --- | --- |
| Sheet prepared by: |  | Nurse |
| Sheet prepared by: |  | Doctor |

|  |  |
| --- | --- |
| DATE: |  |

I agree to pay the full cost of the vaccines before administration.

|  |  |
| --- | --- |
| PATIENT'S SIGNATURE: |  |

|  |  |
| --- | --- |
| DATE: |  |