## You

First Name ______ Last Name ______ Age ______
Date of Birth ______ Sex M ☐ F ☐ Email Permanent ______
Nationality ______ Country of Birth ______
Current Address ______
Suburb / City ______ Country ______
Permanent Address (if different from above) ______
Suburb / City ______ Country ______
Phone No. (H) ______ (W) ______ (mobile) ______
Occupation ______ Company / Organisation ______
Notes to be sent to GP Yes ☐ No ☐ GP's Name & Surgery ______

## Your Health

1. Have you travelled to less developed countries before? ........ Yes ☐ No ☐
   Did you have any health problems while away? ______
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? .. Yes ☐ No ☐
   If yes, please specify ______
3. Do you have a **family** history of blood clots, depression, schizophrenia, anxiety attacks or mental illness? ........ Yes ☐ No ☐
   If yes, please specify ______
4. Do you **regularly** take or **occasionally** take any medications? (prescription and non-prescription)..... Yes ☐ No ☐
   Name of all medications ______
5. Are you allergic to anything? e.g. sulphur drugs, penicillin, tetracyclines, neomycin, mercury/thiomersal, gelatin, eggs, iodine, latex, bandaids, insect bites? ........ Yes ☐ No ☐
   If yes, please specify ______
6. Have you been in hospital, been ill or injured in the last 6 weeks? ______ Yes ☐ No ☐
7. Are you currently undergoing any medical investigations / treatment?........ Yes ☐ No ☐
   If yes, please specify ______
8. Have you had immune globulin or a blood transfusion in the last 12 months? ........ Yes ☐ No ☐
9. Have you ever felt faint or fainted after an injection or giving blood?........ Yes ☐ No ☐
10. Women only: Are you pregnant or planning to become pregnant while travelling or within 3 months of your return?........ Yes ☐ No ☐
11. Did you *miss* any of the usual childhood vaccines?........ Yes ☐ No ☐
12. Do you have any particular health concerns regarding this trip?........ Yes ☐ No ☐
    Please outline ______

## Your Trip

13. Please list in order the countries you intend visiting, and how long (in weeks) you plan to spend in each:
    (i) ______ (____ wks) Drs.use.only........
    (ii) ______ (____ wks) ........
    (iii) ______ (____ wks) ........
    (iv) ______ (____ wks) ........
    (v) ______ (____ wks) ........
    (vi) ______ (____ wks) ........
    (vii) ______ (____ wks) ........
    (viii) ______ (____ wks) ........
14. What is the main purpose of your trip? Holiday ☐ Visiting family/friends ☐ Business Trip ☐ Other ☐
15. Type of accommodation? Camping ☐ Budget ☐ Air-conditioned hotel ☐ Private Home ☐ Other ☐
16. Planned activities? Trekking/Altitude ☐ Scuba Diving ☐ Cycling ☐ Rafting/Boating ☐ Other ☐
17. Date leaving this city ______
18. Date leaving New Zealand ______
19. Return date to New Zealand ______
20. Place of departure from New Zealand ______

## Other

21. How did you learn of this Travel Doctor:
    Travel Agent: ☐ (which one?) ______ Publication: ☐ (which one?) ______
    Doctor ☐ (please name) ______ Website ☐ (please specify) ______
    Friend ☐ Workplace ☐ (please specify) ______ Other ☐ (please specify) ______

Your signature ______ *Thank you! Can you please take this form back to the receptionist.*

*Date* ___/___/___

First Name ______________ Last Name ______________ Age ______

| CLINIC USE ONLY<br>Disease/Vaccine PHx | Schedule:<br>Vaccine Rx: | V1<br>Date: | V2 | V3 | V4 | V5 | V |
|---|---|---|---|---|---|---|---|
| Polio | | | | | | | |
| Td | | | | | | | |
| Tdap | | | | | | | |
| Tdap-IPV | | | | | | | |
| MMR | | | | | | | |
| Varicella | | | | | | | |
| Flu | | | | | | | |
| Pneumonia | | | | | | | |
| Typhoid | | | | | | | |
| Hep A | | | | | | | |
| Hep A+Typhoid | | | | | | | |
| Hep B | | | | | | | |
| Hep A+B | | | | | | | |
| Meningitis | | | | | | | |
| Yellow Fever | | | | | | | |
| Cholera/ETEC | | | | | | | |
| Jap Enceph | Jespect | | | | | | |
| Rabies | IM/0.1ml ID | | | | | | |
| BCG Scar / No Scar | | | | | | | |
| QF Gold / Mantoux | | | | | | | |
| Malaria Chemoprophylaxis<br>Doxy - Mefloquine - Atovaquone/P | | | | | | | |
| Medical Kit | | | | | | | |
| ADVICE CHECK LIST Tick<br>Food/water ☐<br>Insect avoidance ☐<br>DVT risk/prevention ☐<br>Sexual/Reproductive Health ☐<br>Personal safety/Insurance ☐<br>Drug Interactions ☐<br>Altitude ☐<br>Activity advice: ☐<br>☐<br>Yellow Book ☐<br>Section 29 ☐<br>ID rabies ☐ | | | | | | | |
| IHG ☐ | | | | | | | |
| Doctors Signature | | | | | | | |
| RN Signature | | | | | | | |

First Name ______________________ Last Name ______________________

Staple results here

**Medical Notes:**

## Consent to vaccinate:

I ______________________ consent to receiving the vaccinations as prescribed on the previous page of this document. The known risks associated with administration of these vaccines have been discussed with me and the possibility of a rare adverse event or vaccine failure has been explained to me. I understand I need to remain at The Travel Doctor Clinic for 15-30 minutes following my vaccinations.

| Patient | Witness |
| --- | --- |
| Name ______________ | Name ______________ |
| Signature ______________ | Signature ______________ |
| Date ______________ | Date ______________ |