

TRAVEL CLINIC EAST PERTH: PRE-TRAVEL ASSESSMENT FORM



TO BE COMPLETED BY THE PATIENT

Mr / Mrs / Ms / Dr Surname: _____ First name: _____

Date of birth: ____ / ____ / ____ Occupation: _____

Contact Number: _____ Mobile Number: _____

Address: _____ Postcode: _____

Please provide your email address for your travel updates:

I will pay by: Cash Eftpos Visa Mastercard AMEX

I have Private Health Extras cover: Yes No

I heard about The Travel Clinic East Perth from *(please tick and provide details where possible)*:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Website _____ | <input type="checkbox"/> GP _____ |
| <input type="checkbox"/> Travel Agent _____ | <input type="checkbox"/> Friend _____ |
| <input type="checkbox"/> Yellow pages _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> White Pages _____ | |

Personal Medical History

Are you well today? Yes No

Is your general health good? Yes No

Have you ever fainted or felt unwell soon after an injection? Yes No

Have you ever had a serious reaction to a vaccine before? Yes No

Have you received any vaccines in the past month? Yes No

Are you currently on steroids? Yes No

Are you allergic to eggs, medication or other substances? Yes No

List allergies: _____

Have you received any blood products or had a blood transfusion in the past year? Yes No

Does someone with lowered immunity live at home with you? Yes No

Do you or any close family member have epilepsy? Yes No

Do you have any history of Guillian-Barre Syndrome? Yes No

Have you suffered from any of the following:

Jaundice/Hepatitis Yes No

Blood clots/DVT Yes No

Ear/Hearing problems Yes No

Cancer/Radiotherapy/Chemotherapy Yes No

HIV/AIDS Yes No

Thymus disorder Yes No

Diabetes Yes No

Lung disease Yes No

Do you have any history of mental illness including depression/anxiety? Yes No

Please list all current medication: _____

Women Only: Are you pregnant, planning a pregnancy or currently breast feeding? Yes No

Vaccine History

Please indicate which year the following vaccines were given. Also indicate if you have had any of the diseases.

You can check with your G.P. or previous medical records to find this information.

Vaccine Given	Year
Tetanus/Diphtheria/Pertussis (Whooping Cough)	
Polio	
Measles/Mumps/Rubella	
Varicella (Chicken Pox)	
Pneumovax	
Influenza	
Hepatitis A	
Hepatitis B	
Typhoid	
Yellow Fever	
Meningococcal	
Rabies	
Cholera	
Japanese Encephalitis	
Tick-Borne Encephalitis	
Q Fever	
Mantoux/BCG	
Other: _____	

Have you had anti-malarial tablets in the past?

Lariam	Yes	No
Doxycycline	Yes	No
Malarone	Yes	No
Other: _____	Yes	No

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Please list all countries that you have previously visited:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all the countries to be visited in order of visits:

Duration (days, weeks, months):

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Date of Departure: _____

Length of Stay: _____

Tick the following that applies to your trip:

Business Trip:

- | | |
|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Onshore | <input type="checkbox"/> Vessel |
| <input type="checkbox"/> Offshore | <input type="checkbox"/> City |
| <input type="checkbox"/> Rig | <input type="checkbox"/> Rural |

Holiday:

- | | | |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Package | <input type="checkbox"/> Trekking | <input type="checkbox"/> Cruise |
| <input type="checkbox"/> Self-organised | <input type="checkbox"/> Adventure | <input type="checkbox"/> Altitude |
| <input type="checkbox"/> City | <input type="checkbox"/> Backpacking | <input type="checkbox"/> Safari |
| <input type="checkbox"/> Rural | <input type="checkbox"/> Camping | <input type="checkbox"/> Other: _____ |

Accommodation:

- | | |
|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Hotel | <input type="checkbox"/> Relative |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Other: _____ |

∞ END OF PATIENT COMPLETION ∞
Please return form to reception.