

PERTH VACCINATION & TRAVEL CENTRE: PRE-TRAVEL ASSESSMENT FORM



TO BE COMPLETED BY THE PATIENT

Salutation: _____ Surname: _____ First name: _____

Appointment Date: _____ / _____ / _____ Appointment Time: _____ AM PM

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

Contact Number: _____ Mobile Number: _____

Address: _____ Postcode: _____

Email Address: _____

YES I would like to receive regular travel updates.

I will pay by: Cash Eftpos Visa Mastercard AMEX

I have Private Health Extras cover: Yes No

I heard about the Perth Vaccination & Travel Centre from (please tick and provide details where possible) :

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

Personal Medical History

YES NO

- 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 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Blood clots/DVT | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ear/Hearing problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer/Radiotherapy/Chemotherapy | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HIV/AIDS | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Thymus disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Lung disease | <input type="checkbox"/> YES | <input type="checkbox"/> 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 / Diptheria / Pertussis (Whooping Cough)	
Tetanus / Diptheria	
Polio	
Measles / Mumps / Rubella	
Varicella (Chicken Pox)	
Hepatitis A	
Hepatitis B	
Hepatitis A / Typhoid	
Typhoid	
Yellow Fever	
Meningococcal	
Rabies	
Cholera	
Japanese Encephalitis	
Tick-Borne Encephalitis	
Q Fever	
Mantoux / BCG	
Pneumovax	
Influenza	
Other:	

Have you had anti-malarial tablets in the past?

Malarone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Doxycycline	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lariam	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:

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

Duration (days, weeks, months):

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.