TRAVEL HEALTH ASSESSMENT

Doctor _____

Surname _____**Given Name**_____ Mr / Mrs / Miss / Ms

Address _____ **Suburb**_____**Postcode**_____

Phone (H) _____**Mobile** _____ **Date of Birth** _____

Contact Consent (reminder for vaccines) Yes no

Are you receiving a □ Pension □ Department of Veterans Affairs □ Health Care Card

Pension Number _____ Expiry Date _____Part/Full pension

Medicare Card Number __ __ __ __ __ __ __ __ __ __ __ Reference Number _____ Valid To _____

I accept responsibility for this account (consultation and vaccines) and will be paying today by the following method.
□ Cash □ Credit Card □ EFT

Are you travelling overseas for work? Yes / No If Yes, which company _____

Your Occupation _____ Departure date_____

I will be visiting the following countries:

Country (in order of visit)	**Duration**	**Accommodation (tent/hotel/backpack)**	**Staying in main tourist Cities only? Yes / No**

Is your general health good? □ Yes □ No
Could you be pregnant while away? □ Yes □ No
Will children be travelling with you? □ Yes □ No
Are you allergic to eggs, medications or other substances? □ Yes □ No
Are you or anyone in your household possibly immune deficient eg on chemotherapy for cancer or immunosuppressant medication or injections? □ Yes □ No
Do you have ear troubles when flying? □ Yes □ No

Please list:
Countries you have visited previously: _____
Medications or regular injections you are currently taking/receiving: _____
Past medical / health problems you have had here and overseas and especially note past history of jaundice, hepatitis, ear or hearingproblems_____
_____
Would you like information on medical kits for travellers to prevent illness? □ Yes □ No
Your family doctors name and address: _____

Please indicate which year the following vaccines were given:

VACCINE	**YEAR GIVEN**	**VACCINE**	**YEAR GIVEN**	**VACCINE**	**YEAR GIVEN**
Tetanus/Diptheria		Typhoid		Meningitis	
Polio		Cholera		Yellow fever	
Flu Vaccine		Hepatitis B		Mantoux/BCG	
Pneumovax		Hepatitis A		Rabies	
Measles/Mumps/Rubella		Hepatitis A Immunoglobulin		Japanese Encephalitis	

How did you hear about us? □ Travel Clinics Australia □ Web/Internet □ Yellow Pages □ Work
□ Family, if so who? _____ □ Personal Recommendation by _____
□ Travel Agent, who?_____ □ Other _____

PRE –IMMUNISATION CHECKLIST

Doctor:

*Please read the following and inform the Doctor/Nurse **prior to immunisation** if any of the conditions apply to you.*

- ☐ Unwell on day of immunization (fever over 38.5 C)
- ☐ A severe reaction to any vaccine in the past
- ☐ A severe allergy to anything else
- ☐ Are pregnant or planning pregnancy within one month of immunization
- ☐ Preterm baby, born less than 32 weeks
- ☐ Had a 'live' vaccine in the last month (Measles-Mumps-Rubella (MMR); Chicken Pox; Tuberculosis (BCG); Yellow Fever)
- ☐ Have (or live with someone with) a disease requiring treatment causing low immunity (eg: leukaemia, cancer, HIV/AIDS ,radiotherapy or chemotherapy, taking prednisolone, cortisone,methotrexate)
- ☐ Had immunoglobulin or blood transfusion in last 3 months, or intravenous immunoglobulin in last 9 months
- ☐ Infants under 12 months, whose mother has had immunosuppression therapy during pregnancy eg TNF inhibitors (infliximab, adalimumab).
- ☐ Have a past history of Guillain-Barre syndrome
- ☐ Are of Aboriginal or Torres Strait Island descent
- ☐ Are suffering from Multiple Sclerosis

I have read and understood the above information prior to immunisation:

Patient Name_____ DOB_____

Parent/Gaurdian name (if patient under age)_____

Sign _____ Date _____

Privacy Statement – Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised personnel.