**Upper Hutt Travel Clinic**

Upper Hutt Health Centre, Queen Street Car Park, Queen Street, Upper Hutt. – Phone 920 1800

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**Pre Travel Questionnaire**

* It is essential that you visit our travel doctor well in advance of travelling overseas (preferably 6 weeks before).
* The travel doctor will be able to advise you personally regarding vaccinations, malaria prevention and general health issues you should consider for your destination.
* To help us have all the right information for your appointment, print this form, complete the details, and post it back to us.

**Please bring to your appointment: Vaccination records (childhood/travel) and your travel itinerary.**

|  |  |
| --- | --- |
| Name: | Date: |
| Address: | |
| Ph: Home: Work: Cell: | |
| Email: | Date of Birth: |

Immunisation Record

**Please answer the following questions to the best of your ability, they will be discussed further during your consult.**

Immunised as a child? □ Yes □ No Birthplace\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Date of Departure: | |
| Countries and Towns you are travelling to:( please specify) Duration of stay: | |
|  |  |
|  |  |
|  |  |
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**Activities planned during travel:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| □ Rural/remote | □ Diving | □ High Altitude | □ Surfing | □ Camping |
| □ Urban/city | □ Climbing | □ Snorkelling | □ Touring |  |
| □ Other (please specify) | | | | |

**I would define my travel as:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| □ Business/work | □ Vacation | □ Volunteer/mission | □ Backpacking | □ Visiting family |
| □ Other (please specify) | | | | |

**Medical Conditions:** □ **None Yes No Yes No**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| High blood pressure |  |  | Leukaemia/Lymphoma/Recent cancer |  |  |
| Psoriasis |  |  | Recent chemotherapy (last 4 months) |  |  |
| Emotional/Psychiatric Condition |  |  | Recent radiation (last 4 months) |  |  |
| Seizure Disorder |  |  | Immunocompromised or immunosuppressed |  |  |

**Medical Conditions continued……. Yes No Yes No**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Lung/Respiratory Condition |  |  | Spleen Removed/No Spleen |  |  |
| Migraines |  |  | Organ/Bone Marrow transplant |  |  |
| Digestive Tract Problems |  |  | Pregnant or planning to become pregnant |  |  |
| Heartburn/Acid reflux |  |  | Diabetes |  |  |
| Arhythmia/Heart condition |  |  | High Cholesterol |  |  |
| DVT (Deep Vein Thrombosis) |  |  | Sinus/Ear Problems |  |  |
| Other (please specify) | | | | | |

**Have you been vaccinated in the past 4 weeks?** □ Yes □ No

If yes, which vaccine?

**What prescribed and over the counter medications do you take?**

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| --- |
|  |
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|  |
|  |

**Yes No**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug allergies |  |  |  | |
| Other allergies |  |  |  | |
| Anaphylactic Reaction |  |  |  | |
| Have you had any adverse reaction to an anti-malarial? If yes, which one? |  |  |  | |
| Please check if you are allergic to: | Latex □ | | Eggs/Chicken □ | Adhesive Bandages □ |

**How did you hear of our travel clinic?**

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**Are there any other issues or concerns that we need to know about?**