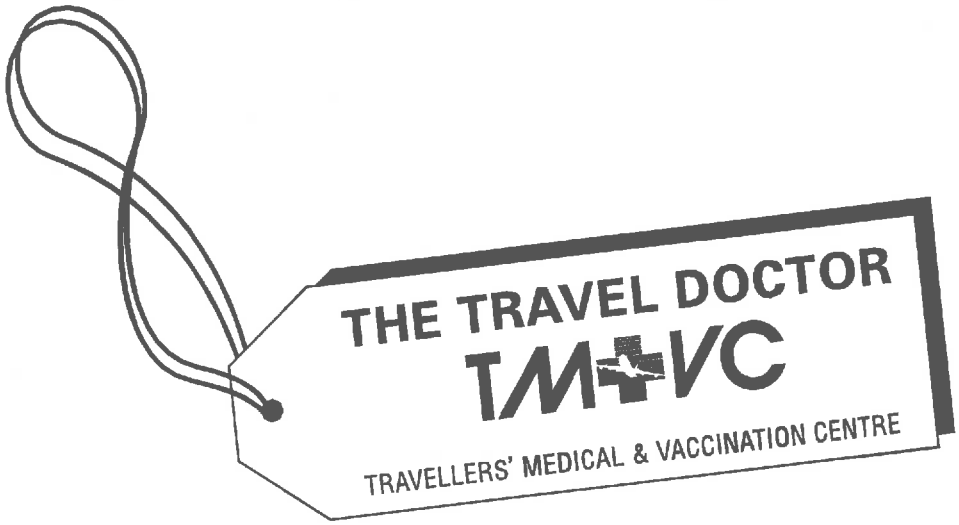
DATE OF BIRTH	FIRST NAME	LAST NAME



...for a safe and healthy journey

TRAVELLERS MEDICAL RECORD

(CONFIDENTIAL INFORMATION ENCLOSED)

Thank you
for taking the time to fill in this questionnaire.

Your answers will enable us to give you
the best possible medical preparation for your trip.

Please turn over ...

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 _____

Vaccination record sent to GP? Yes ☐ No ☐ Your Medical Centre is _____

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 Disease/Vaccine PHx	Schedule: Vaccine Rx:	V1 Date:	V2	V3	V4	V5	V6
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 Doxy - Mefloquine - Atovaquone/P							
Medical Kit							

ADVICE CHECK LIST	Tick
Food/water	☐
Insect avoidance	☐
DVT risk/prevention	☐
Sexual/Reproductive Health	☐
Personal safety/Insurance	☐
Drug Interactions	☐
Altitude	☐
Activity advice:	☐
	☐
Yellow Book	☐
Section 29	☐
ID rabies	☐

IHG ☐							
Doctors Signature							
RN Signature							

SERVICES RENDERED GRID

Date																								
Consultation	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd
	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N
Medical																								
Discount % / no charge																								
Chickenpox																								
Cholera																								
Hep A & Hep B																								
Hep A & Typhoid																								
Hep A **Adult**																								
Hep A **Junior**																								
Hep B Adult																								
Influenza																								
Japanese Encephalitis																								
Mantoux/BCG																								
Meningococcal																								
MMR																								
Pneumococcal																								
Polio																								
Rabies **ID**																								
Rabies **IM**																								
Shingles																								
Td																								
Tdap																								
Tdap-IPV																								
Typhoid **Inj**																								
Typhoid **Oral**																								
Yellow Fever																								
Atlovaquone/Proguanil																								
Doxycycline																								
Mefloquine																								
Gastro Kit																								
Tour Kit																								
Travel Kit																								
Acetazolamide																								
Amoxicillin & Clavulanic Acid																								
Azithromycin																								
Betadine																								
Ciprofloxacin																								
Fluconazole																								
Hyoscine Butylbromide																								
Loperamide																								
Loratadine																								
Ondansetron																								
Ornidazole																								
Prochloperazine																								
Rehydration sachets																								
Roxythromycin																								
Zopiclone																								
Total Cost $																								
Receptionist signature																								
Method of payment																								

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 _____

SERVICES RENDERED GRID

Date																					
Consultation	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd	☐ Sd	☐ Cp	☐ Cd
	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N	☐ Sh	☐ F/U	☐ Sd N
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