|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title | Mr. | Mrs. | Ms. | Miss | Dr | Other | | | | | | | | | | | | | | |
| Last name |  | | | | | | | First name | | | |  | | | |
| Date of birth |  | | | |
| Occupation |  | | | | | | | | | | | | | | |
| Trip | Holiday | Business | other | | | | | | | | | | | | | | |
| Mobile phone number |  | | | | Daytime phone no. | | | | | | |  | | | |
| Email address |  | | | | | | | | | | | | | | |
| Home address |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Departure date |  | | | | | Return date | | | |  | | | | | |
| Countries to be visited | Country (in order of visit) | | | Duration (days/weeks) | | | Accommodation (hotel / tent / backpack / other) | | | | | | Activities | | |
|  | | |  | | |  | | | | | |  | | |
|  | | |  | | |  | | | | | |  | | |
|  | | |  | | |  | | | | | |  | | |
|  | | |  | | |  | | | | | |  | | |
| Please list other countries visited in prior trips | | | | | | | | | | | | | | | |
| Have you ever fainted or felt unwell soon after an injection | | | | | Yes No | | | | | | | | | | |
| Could you be pregnant while away (females only) | | | | | Yes No | | | | | | | | | | |
| Does someone with lowered immunity live at home with you | | | | | Yes No | | | | | | | | | | |
| Will children be travelling with you | | | | | Yes No | | | | | | | | | | |
| Are you allergic to: | | | | | eggs – yes no | medications – yes no | | | | | | | | | | |
|  | | | | | other substances yes no | | | | | | | | | | |
| Please list these allergies | | | | | | | | | | | | | | | |
| Please list ALL medications you are currently taking (or attach list) | | | | | | | | | | | | | | | |
| Please past significant medical and/or health problems you have had both here and overseas. Especially, note past history of jaundice, hepatitis, deep vein thrombosis (DVT) or blood clots, ear or hearing problems or have a disease which lowers immunity (eg: cancer, HIV/AIDS, thymus disorder). *Use back of page if more space required* | | | | | | | | | | | | | | | |
| In order to avoid unnecessary vaccinations along with extra charges, you need to complete the following table before your appointment.  Please list approximate year you had any of the following vaccinations or diseases, including measles, mumps, rubella, chicken pox as well as the date of your last tetanus vaccine. You can check with your GP or previous medical records to find this information. | | | | | | | | | | | | | | | |
| Vaccine given | | Year | Vaccine given | | | | | | Year | | Vaccine given | | | Year |
| Tetanus / diphtheria / whooping cough (pertussis) | |  | Typhoid | | | | | |  | | Mantoux /BCG | | |  |
| Polio | |  | Cholera | | | | | |  | | Meningococcal | | |  |
| Seasonal flu | |  | Hepatitis B | | | | | |  | | Japanese encephalitis | | |  |
| Swine flu (H1N1) | |  | Hepatitis A | | | | | |  | | Q fever | | |  |
| Pneumovax | |  | Gardasil (cervical cancer) | | | | | |  | | Rabies | | |  |
| Measles / mumps | |  | Varicella (chicken pox) | | | | | |  | | Yellow fever | | |  |

Would you like information on medical kits for travelers to prevent illness? Yes No

|  |  |
| --- | --- |
| Doctor to discuss with patient: | Comments |
| Food / Water / Hygiene |  |
| Malaria |  |
| Travel Insurance |  |