the doctors

Travel Health Questionnaire

Before you head off on your exciting adventure please complete this travel health questionnaire and return it to the medical centre for a pre-assessment. Then we can book your travel health appointment. Complete all sections so that we can ensure we are able to provide you with the best medical advice for your trip.

YOUR DETAILS

Please complete all details

Surname:		First names:	
Age:	D.O.B:	Sex at birth:	Gender you identify as:
COMPLETE IF THE TRAVELLER IS UNDER 16YRS AND YOU ARE A PARENT OR GUARDIAN Your Full Name:		Your relationship:	
Country of Birth:		Nationality:	
Address:			
City:		Postcode:	
Home Phone:		Mobile:	
Medical Centre:		GP Name:	
Would you like a copy of the notes sent to your GP? Yes ◯ No ◯			
How did you hear about The Doctors Travel Health Services?			

CURRENT HEALTH & PREVIOUS TRAVEL HEALTH EXPERIENCES Please tick the box that applies for you and explain or specify in detail where requested		CLICK **YES**	CLICK **NO**
1.	Have you travelled previously to any less developed countries,? e.g. parts of central and northern Africa, India, Nepal, Afghanistan, Bangladesh, Cambodia, Myanmar, Peru, parts of South America	◯	◯
	If **yes**, specify:		
	If **yes**, did you have an illness while travelling? **Please explain:**		
Questions 2 – 11 to be answered by all casual patients or those NOT enrolled with The Doctors. Current information on these issues are held in the practice for all enrolled patients.			
2.	Do you have or have you ever had any medical problems? E.g. Blood clots, asthma or any other breathing problems, 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, or thyroid disorders?	◯	◯
	If **yes**, specify:		
3.	Do you have family history of blood clots?	◯	◯
	If **yes**, specify:		
4.	Do you regularly take or occasionally take any medications? (prescription and non prescription) eg: contraceptive pill, antibiotics, migraine tablets, inhaler, vitamins	◯	◯
	If **yes**, list all medications:		

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CURRENT HEALTH & PREVIOUS TRAVEL HEALTH EXPERIENCES... CONTINUED Please tick the box that applies for you and explain or specify in detail where requested		YES	NO
5.	Are you allergic to anything? E.g. sulphur drugs, penicillin, tetracycline's, neomycin, gelatin, any foods including eggs, iodine, latex, band aids, insect bites?	◯	◯
	If **yes**, specify:		
6.	Have you been in hospital, been ill or injured in the last 6 weeks?	◯	◯
	If **yes**, outline:		
7.	Are you currently undergoing or recently had any medical investigations/treatments? eg HIV, post-transplant, chemotherapy?	◯	◯
	If **yes**, outline:		
8.	Have you had immune globulin or a blood transfusion in the last 12 months?	◯	◯
9.	Have you ever had hepatitis?	◯	◯
10.	Have you ever had COVID-19?	◯	◯
	If **yes**, when was your most recent infection?		
11.	Have you had any previous vaccinations?	◯	◯

If yes, list these including date/year of last dose:

	Date	Yes	No		Date	Yes	No		Date	Yes	No
Diptheria/Tetanus	/ / DAY MONTH YEAR	◯	◯	Typhoid	/ / DAY MONTH YEAR	◯	◯	Influenza	/ / DAY MONTH YEAR	◯	◯
Hepatitis A	/ / DAY MONTH YEAR	◯	◯	Hepatitis B	/ / DAY MONTH YEAR	◯	◯	COVID-19	/ / DAY MONTH YEAR	◯	◯
	If yes, # of doses?				If yes, # of doses?				If yes, # of doses?		
MMR (Mumps, Measles, Rubella)	/ / DAY MONTH YEAR	◯	◯	Rabies	/ / DAY MONTH YEAR	◯	◯	Meningitis	/ / DAY MONTH YEAR	◯	◯
	If yes, # of doses?				If yes, # of doses?						
Yellow Fever	/ / DAY MONTH YEAR	◯	◯	Polio	/ / DAY MONTH YEAR	◯	◯				

Questions 12 – 18 are to be answered by all travellers.			
12.	Have you received any vaccinations during the past four weeks?	◯	◯
13.	Are you about to be or recently under the care of any Medical or Surgical specialists?	◯	◯
14.	Are you breastfeeding, currently pregnant, or planning to become pregnant while travelling or within 3 months of your return?	◯	◯
15.	Have you ever had a serious reaction to a vaccination?	◯	◯
	If **yes**, specify:		
16.	Do you you know what vaccines you need for this trip?	◯	◯
	If **yes**, outline:		
17.	Do you need a prescription for your usual medicines and/or additional medicines required for this trip?	◯	◯
	If **yes**, specify:		
18.	Do you have any further queries about health concerns or wellness needs during this trip?	◯	◯
	If **yes**, outline:		

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UPCOMING DETAILS

If you have a finalised itinerary please attach it to this form or complete all details using your itinerary.

Detail the purpose of your trip e.g. holiday, visiting family or friends, business trip:	
Type of accommodation e.g. camping, budget, backpackers, air conditioned hotel, private home, other (specify):	
Planned activities e.g. rural, urban/cities, trekking, altitude, climbing, scuba diving, cycling, rafting, boating, other (specify):	
Do you have travel insurance?	Yes: ◯ NO: ◯
Date leaving New Zealand:	/ / DAY MONTH YEAR
Date returning to New Zealand:	/ / DAY MONTH YEAR

Unless itinerary is attached, please list in order the countries and their specific regions you intend on visiting?

Country / region 1	Country / region 2
Country / region 3	Country / region 4
Country / region 5	Country / region 6

Type your name here as a signature that all completed personal information is correct

Your/Parent/Guardian signature:
Date: / / DAY MONTH YEAR