

TRAVEL ASSESSMENT



Family Name		Given Name	
Date of Birth		Gender	
Occupation		Country of Birth	
Home Address			
Phone		Email	

Travel Information

Date of departure		Date of return	
Country (in order of visit)	Duration (weeks)	Type of accommodation planned (hotel / hostel / homestay / camping)	

Main reason for travel	Holiday	<input type="checkbox"/> Yes <input type="checkbox"/> No	Visit Friends / Relatives	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Business	<input type="checkbox"/> Yes <input type="checkbox"/> No	Volunteering	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you plan to travel to rural areas?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you plan to do activities in remote or wilderness areas?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Will anyone else be travelling with you?			<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, age/s
Have you previously travelled overseas?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, which of the following regions have you travelled to?	<input type="checkbox"/> Africa <input type="checkbox"/> Middle East <input type="checkbox"/> Europe <input type="checkbox"/> Asia <input type="checkbox"/> North America <input type="checkbox"/> Central / South America <input type="checkbox"/> Pacific Islands <input type="checkbox"/> Other _____			

Health Information

In which country/countries did you spend your childhood?	
Did you complete the recommended childhood vaccinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you allergic to eggs, medications or other substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List ALL allergies	
List ALL medications you are currently taking	
List past significant medical/health problems	

TRAVEL ASSESSMENT



Do you have or have you had any of the following diseases?

Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Deep vein thrombosis (DVT) or blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukaemia, lymphoma or other cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV / AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Vaccination History

Indicate whether you have had the following vaccines, the approximate year received and any adverse reactions. Check with your GP or previous medical records to find this information.

Vaccine	Year	Adverse reactions or comments
BCG		
Cholera		
Hepatitis A		
Hepatitis B		
Influenza (seasonal or H1N1)		
Japanese Encephalitis		
Measles/mumps/rubella		
Meningococcal		
Pneumococcal		
Polio		
Q fever		
Rabies		
Tetanus/Diphtheria/Pertussis		
Typhoid		
Varicella (chicken pox)		
Yellow fever		

Have you ever fainted or felt unwell soon after an injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Female only:</i> Are you pregnant or trying to become pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Female only:</i> Are you breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been tested for TB? (Mantoux test, Quantiferon)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you previously received anti-malarial drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details of drug taken, duration and any adverse reactions	

COMMENTS
