Travel Health Questionnaire

BLACKBURN CLINIC
FAMILY GENERAL PRACTICE

Name: _____ File No: _____

Address: _____

Date of Birth: _____

Date of departure: _____ Date of return: _____ Approx overall length of trip: _____

Travel Itinerary:

Country/countries visiting	Approximate length of stay	Areas visited will be: (Please tick all that apply)		
1.		☐ Urban	☐ Regional	☐ Remote
2.		☐ Urban	☐ Regional	☐ Remote
3.		☐ Urban	☐ Regional	☐ Remote
4.		☐ Urban	☐ Regional	☐ Remote
5.		☐ Urban	☐ Regional	☐ Remote
Future travel plans:		☐ Urban	☐ Regional	☐ Remote

Have you arranged travel insurance? ☐ Yes ☐ No

Trip particulars: (please tick all that apply as your answers may affect the advice given)

Purpose of trip: ☐ Business ☐ Holiday ☐ Visiting family

Trip type: ☐ Package/ Tour ☐ Self-organised ☐ Backpacking ☐ Camping ☐ Cruise ☐ Trekking

Accommodation: ☐ Hotel ☐ Private homes ☐ Hostel/guest house ☐ Onboard boat/ ship ☐ Tent / caravan/ bungalow ☐ Other: _____

Travel companions: ☐ None/ travelling alone ☐ Partner, family, friend ☐ In a group

Visiting area/s that are: ☐ Urban ☐ Rural ☐ At high altitude

Planned activities: ☐ Safari / hiking ☐ Tattoos / piercings ☐ Scuba diving ☐ Scooter /motorbike /bicycle use ☐ Adventure (eg. skydiving, rock climbing, rafting, tubing) ☐ Other: _____

Personal medical history:

	Yes	No
Do you have any recent or past medical history of note? *(including diabetes, heart or lung conditions)*	☐	☐
Do you have a family history of blood clotting disorders, DVT or PE?	☐	☐
Do you have any history of mental illness including depression or anxiety?	☐	☐
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?	☐	☐
Are you currently pregnant, planning pregnancy or breastfeeding? ***Women only***	☐	☐
Do you or any close family members have epilepsy?	☐	☐
Do you have any allergies? *(eg. eggs, antibiotics, nuts)*	☐	☐
Have you ever had a serious reaction to a vaccine given to you before?	☐	☐
Does having an injection make you feel faint?	☐	☐

List any current or repeat medications: _____

Vaccination History:

Have you ever had any of the following vaccinations/ medications? If so, when?
Please select all that apply.

Vaccination/medication		When?	Vaccination/medication		When?
Tetanus	☐		Japanese Encephalitis	☐	
Polio	☐		Rabies	☐	
Diptheria	☐		Cholera	☐	
Pertussis	☐		Typhoid	☐	
MMR	☐		Yellow Fever	☐	
Varicella/ Chicken Pox	☐		Meningitis	☐	
Influenza	☐		Malaria tablets	☐	
Hepatitis A	☐		Other:	☐	
Hepatitis B	☐				

PLEASE PRINT OUT THIS FORM AND BRING IT TO YOUR TRAVEL CONSULTATION.

To be completed by doctor

RECOMMENDATIONS AND TRAVEL ADVICE

Vaccination recommended	☑	Further information
Tetanus	☐	
Polio	☐	
Diptheria	☐	
Typhoid	☐	
Cholera	☐	
Hepatitis A	☐	
Hepatitis B	☐	
Meningitis ACWY	☐	
Yellow Fever	☐	
Japanese Encephalitis	☐	
Rabies	☐	
MMR	☐	
Pertussis	☐	
Varicella	☐	
Travel Pack recommended	☐	
Malaria Prevention advice given:		
Doxycycline	☐	Chloroquine and proguanil ☐
Atovaquone & Proguanil (Malarone)	☐	Mefloquine ☐
Chloroquine	☐	Malaria advice leaflet given ☐

Health Advice given:	☑		☑
Food, water and personal hygiene	☐	Insect bite prevention	☐
Traveller's diarrhoea	☐	Animal bites	☐
Altitude	☐	Sun/heat protection	☐
Sexual Health	☐	Dental	☐
Accidents – scooters/motorbikes	☐	Travel insurance recommended	☐
www.smarttraveller.gov.au	☐	BBV prevention: tattoo, manicure, piercings, sex	☐
		Immunisation record card supplied	☐

Doctor Name: _____ Date: _____ Doctor's Stamp:

Doctor Signature: _____