GP on Beaufort Pre-Travel Questionnaire Form

The more information we have prior to your visit the better it is for your doctor to research what you need to keep you healthy on your travels.

Name:		**Date of Birth:**
Home Ph:		**Mobile:**
Address:		
Date		

DETAILS

How did you hear about Travel Health Medicine at gp on beaufort? (Please tick/provide details)

☐ Website ☐ GP ☐ Other _____

☐ Travel agent ☐ signs

☐ Yellow pages ☐ friend

☐ White pages ☐ magazine

TRIP INFORMATION

Date of departure	
Length of Stay	
Countries previously visited	

ITINERARY

Please list in order, countries you intend to visit and how long you will spend in each.

If travelling to specific regions/islands within a country, please indicate details (e.g. Bali, Lombok)

Countries	Length of Stay

Destinations ☐ Urban ☐ Rural ☐ Remote

☐ Beach ☐ High Altitude (>2000m)

Is this a fixed Itinerary? ☐ YES ☐ NO ☐ UNSURE

Purpose of Travel: ☐ Vacation ☐ Medical Care

☐ Business ☐ Adoption

☐ Education ☐ Volunteer/Humanitarian

☐ Visiting friends and/or relatives

☐ Long Stay

Organized Tour? ☐ YES ☐ NO ☐ Partly

Explain:

_____

_____

_____

Accommodation:

☐ **High End** ☐ **Intermediate** ☐ **Basic**

☐ 4-5 star hotels ☐ 2-3 star hotel ☐ Backpackers

☐ Safari lodges ☐ work-site ☐ Camping

☐ Rented House/apartment ☐ Cruise ship/boat ☐ Staying with locals/family/friends

Planned Activities

☐ Swimming ☐ Visiting Schools, hospital, orphanages

☐ Snorkelling ☐ Health care worker

☐ Scuba ☐ Occupational Exposure

☐ Rafting/boating ☐ Contact with Animals

☐ Hiking/climbing/trekking ☐ Cave/spelunking

Have you obtained travel medical evacuation insurance? ☐ YES ☐ NO

Health History:			**Vaccine History:** If you have had any of these please provide the year	
Are you well today	☐ YES	☐ NO	Tetanus/ Diphtheria/ Pertussis (Whooping Cough)	
Are you generally in good health?	☐ YES	☐ NO	Tetanus/Diphtheria	
Have you ever fainted after injections?	☐ YES	☐ NO	Polio	
Have you ever had a serious reaction to vaccines before?	☐ YES	☐ NO	Measles/Mumps/Rubella	
			Varicella (chicken Pox)	
Have you received any vaccinations this month?	☐ YES	☐ NO	Hepatitis A	
			Hepatitis B	
Have you ever experienced anaphylaxis (Severe allergic reaction)	☐ YES	☐ NO	Hepatitis A/ Typhoid	
			Typhoid	
Are you currently taking steroids?	☐ YES	☐ NO	Yellow Fever	
Are you allergic to eggs?	☐ YES	☐ NO	Meningococcal	
Are you allergic to any Medications? (e.g. Penicillin Neomycin, Sulphur, Iodine)	☐ YES Details:	☐ NO	Rabies	
			Cholera	
Are you allergic to any other substances? (Please list them)	☐ YES Details:	☐ NO	Japanese Encephalitis	
			Tick-Borne Encephalitis	
Have you received blood products/ blood transfusions in the past year?	☐ YES	☐ NO	Q Fever	
			Mantoux/BCG	
Do you live/work with someone with lowered immunity?	☐ YES	☐ NO	Pneumovax	
			Influenza	
Have you ever had a TB test?	☐ YES	☐ NO	Other:	

Any Additional Information related to the above:

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Have you ever suffered from any of the following?

Anaphylaxis - (severe allergic reaction)?	☐ YES	☐ NO
Altitude Sickness	☐ YES	☐ NO
DVT/Blood Clots	☐ YES	☐ NO
Hepatitis/Jaundice	☐ YES	☐ NO
Hearing problems	☐ YES	☐ NO
Cancer/radiotherapy/chemotherapy	☐ YES	☐ NO
HIV	☐ YES	☐ NO
Thymus Disorder – (Myasthenia gravis, Di George Syndrome)	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Lung Disease	☐ YES	☐ NO
Mental Illness (depression/anxiety/schizophrenia)	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO
Rheumatoid Arthritis	☐ YES	☐ NO
Spleen removed	☐ YES	☐ NO
Tendonitis/Achilles rupture	☐ YES	☐ NO

MEDICATIONS:

Please list ALL prescribed and over-the-counter medications and supplements you use:

Medications: (please list)

When was your last visit to the dentist? (year) _____

WOMEN ONLY are you:

Currently Pregnant? ☐ YES ☐ NO

Likely to get pregnant within 3 months? ☐ YES ☐ NO

Breast feeding? ☐ YES ☐ NO

Please add any additional information you think may be of value to the doctor regarding your health or the planned trip:

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PLEASE COMPLETE AND RETURN TO US IN PDF FORMAT PRIOR TO YOUR APPOINTMENT

Email: reception@gponbeaufort.com.au OR Fax: 08 9262 8699