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.

DETAILS

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

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
☐High Altitude (>2000m) ☐Beach

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

Purpose of Travel:

☐ Vacation
☐ Business
☐ Education
☐ Visiting friends and/or relatives
☐ Long Stay
☐ Medical Care
☐ Adoption
☐ Volunteer/Humanitarian

Organized Tour? ☐ YES ☐ NO

☐ Partly

Explain:

_____

_____

_____

_____

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_____

Accommodation:

☐High End (4-5 star hotels Safari lodges)

☐Intermediate (2-3 star hotel work-site

☐Basic (backpackers, camping)

☐Rented House/apartment

☐staying with locals (friends, family)

☐Cruise Ship/Boat

Planned Activities

☐Swimming
☐Snorkeling
☐Scuba
☐Rafting/boating
☐Hiking/climbing/trekking
☐Cave/spelunking
☐Visiting Schools, hospital, orphanages
☐Health care worker
☐Occupational Exposure
☐Contact with Animals

Have you obtained travel medical evacuation insurance ☐YES ☐NO

Please answer all the questions by ticking the boxes. In the year be as specific as you can.

Health History	Vaccine History	Year
Are you well today? ☐YES ☐NO	Tetanus/Diptheria/Pertussis (whooping cough)	
Are you generally in good health? ☐YES ☐NO	Tetanus/Diptheria	
Have you ever fainted after injections? ☐YES ☐NO	Polio	
Have you ever had a serious reaction to vaccines before? ☐YES ☐NO	Measles/Mumps/Rubella	
Have you received any vaccinations this month? ☐YES ☐NO	Varicella (Chicken Pox)	
	Hepatitis A	
Have you ever experienced anaphylaxis? (Severe allergic reaction) ☐YES ☐NO	Hepatitis B	
	Hepatitis A/Typhoid	
Are you currently taking steroids? ☐YES ☐NO	Typhoid	
Are you allergic to eggs? ☐YES ☐NO	Yellow Fever	
Medications? (e.g. Penicillin Neomycin, Sulphur, or Iodine) ☐YES ☐NO	Meningococcal	
	Rabies	
Or other substances - (please List)	Cholera	
	Japanese Encephalitis	
Have you received blood products/ blood\transfusions in the past year? ☐YES ☐NO	Tick-Borne Encephalitis	
	Q Fever	
Do you live/work with someone with lowered Immunity? ☐YES ☐NO	Mantoux/BCG	
	Pneumovax	
Have you ever had a TB test? ☐YES ☐NO	Influenza	
	Other	

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

ALLERGIES: (please list)

MEDICATIONS:

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

_____

_____

_____

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

WOMEN ONLY are you:

☐ Currently pregnant
☐ Likely to get pregnant within 3 months
☐ Breast feeding

Any Additional Information you think may be of value to the doctor:

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PLEASE COMPLETE AND RETURN to E-MAIL travel@gponbeaufort.com.au or via fax on 08 92628699 prior to your appointment date.