# Pre-Travel Consultation Form.
# Complete all parts and bring to consultation with Travel Doctor

PERSONAL DETAILS

Surname…… Given name……..……..

Date of birth:……/……/……. Age:……. Sex: M…./F……

Country of birth:……Occupation……Employer:……..……..

Address:…… Suburb……. Postcode……..

Phone No. (H)……(W)……. (Mobile)……..

Email Address:……

Medicare Number …….. Reference no……..Expiry ……/…../……

Private Health Insurance: Yes / No

Fund:……

"Extras" Cover: Yes / No

How will you be paying for today's visit?

Cash……EFTPOS……..Visa…….Mastercard……Bankcard……Company account……

Details of Company who will pay for consultation and vaccines

……

.

Would you like information on our medical kits for travelers? Yes / No

Would you like information on our travel products (e.g. permethrin nets ) Yes / No

HEALTH DETAILS

1. Do you have any medical problems? (e.g. asthma, diabetes, mental health illness) Yes / No

If yes, please elaborate……..

2. Are you taking any regular medications(e.g. antibiotics, the conctraceptive pill ) Yes / No

3. Are you allergic to anything? (e.g. eggs, drugs, bee stings, bandaids) Yes / No

If yes, please elaborate……

4. Have you ever felt faint or fainted after an injection or a blood test. Yes / No

5. Have you ever had any health problems while away? Yes / No

If yes, please elaborate……

6. Do you have any particular health concerns regarding this trip? Yes / No

If yes, please elaborate…….

7. Women Only: Are you pregnant or planning to become so within 3 months of your return? Yes / No

8. Are you breastfeeding? Yes / No

9. Are you taking any medicine prescribed by a doctor eg. Corticosteroid medicine such as Cortisone or Prednisone? Yes / No

If yes, please elaborate…….

10. Have you been vaccinated with a live vaccine in the last three months including Tuberculosis, MMR, Chicken Pox, Rotavirus or Yellow Fever or had an injection of immunoglobulin or a whole blood transfusion? Yes / No

If yes, please elaborate…….

11. Do you have a past history of Guillain-Barre syndrome Yes / No

If yes, please elaborate…….

12. Do you have a disease that lowers immunity eg. Lukemia, cancer, HIV / AIDS or are you having treatment which lowers immunity, eg. steroid medicines such as Cortisone, Prednisone, Radiotherapy or Chemotherapy? Yes / No

If yes, please elaborate…….

13. Do you have a chronic illness? Yes / No

If yes, please elaborate…….

14. Are you feeling unwell today? Yes / No

If yes, please elaborate…….

15. Have you ever had a reaction following any vaccine? Yes / No

If yes, please elaborate…….

TRAVEL DETAILS

Please list in chronological order the COUNTRIES you intend visiting.

| Destination (Country) | Date of Arrival | Duration (days) | Living Conditions |
|---|---|---|---|
| 1. | | | A B C D |
| 2. | | | A B C D |
| 3. | | | A B C D |
| 4. | | | A B C D |
| 5. | | | A B C D |
| 6. | | | A B C D |
| 7. | | | A B C D |
| 8. | | | A B C D |
| 9. | | | A B C D |
| 10. | | | A B C D |
| | | | |

A = In transit. Not leaving the airport. B = Hotel in major city/resort
C = Budget accommodation in town/city. D = Trekking and /rural travel.

1. What is the main purpose of your trip? Holiday… Business……Other……
2. Date departing Australia?...../…../……. Date returning to Australia…./…./….
3. Are you travelling with children? Yes / No

VACCINATION DETAILS

1. Did you miss any of the usual childhood vaccinations? Yes / No
2. Have you ever had the following vaccinations?

| Vaccine | Year | Never | Do not know |
|---|---|---|---|
| Tetanus | | | |
| Polio (oral Sabin) | | | |
| Cholera | | | |
| Typhoid | | | |
| Hepatitis A | | | |
| Hepatitis B | | | |
| Meningitis | | | |
| Yellow Fever | | | |
| Pneumovax | | | |
| Jap Encephalitis | | | |
| Rabies | | | |
| Tuberculosis | | | |
| Chicken Pox | | | |

POSSIBLE VACCINATION REACTIONS

Injection Site Reactions

You may develop localized swelling, redness, itching and heat at the injection site. It is common to feel heaviness / pain in the injected limb.

Tell Your Doctor if you experience:

Local soreness, tiredness, headache, body ache, chills, low grade fever, muscle pain, abdominal pain, nausea, diarrhea, vomiting, irritability, impaired sleep, cough, loss of appetite, restlessness, drowsiness, dizziness, earache, or nervousness.

See Your Doctor Immediately if any of the following occur

High fever above 40C, severe dizziness, abscess at the injection site, a severe headache, confusion, unusual bleeding, bruising, purple spots on skin, skin rash, itchy spots or red lumps on skin, itchiness, hives or rash over the body, painful, swollen joints, decreased sensation in the injected limb.

Immediately go to emergency department of your nearest hospital or call an ambulance on 000 if there are:

Sudden signs of allergy such as redness, itchy rash or hives, swelling of the face, lips, tongue or any other part of the body, swelling of the whole arm or leg.
Shortness of breath, wheezing or trouble breathing.
Unusual stiffness causing loss of movement, a seizure or a convulsion which may be accompanied by a high temperature, unusual bleeding, bruising and purple spots on skin, feeling very weak or paralysed.
Rapid, shallow breathing, cold clammy skin, a rapid weak pulse, dizziness, weakness and fainting (shock).
Headaches and high temperature associated with hallucinations, confusion, paralysis of part or all of the body, disturbances of behavior, speech and eye movements, stiff neck and sensitivity to light.

You will be required to wait in the Health Service for 15 – 30 mins after your vaccine.

CONSENT

I acknowledge that:
The doctor has explained the proposed procedure, I understand the risk of immunizations including the risks to me and the likely outcomes.
The doctor has explained other relevant treatment options and their associated risks.
The doctor has explained my prognosis and the risks of not having immunization.
The doctor has explained to me that if immediate life-threatening events happen during the immunization they will be treated accordingly.

I have answered all the preceding questions to the best of my knowledge and I consent to receiving the recommended vaccinations.
I understand there will be an extra cost for the vaccinations which is payable at the time it is administered.

Please sign ……Date / /

Drs Use Only

| | Visit 1 | | Visit 2 | | Visit 3 | | Visit 4 | |
|---|---|---|---|---|---|---|---|---|
| Date | / / | | / / | | / / | | / / | |
| | Doctors please initial when ordered | | | | Please initial when vaccine is given | | | |
| Vaccines | Ordered | Given | Ordered | Given | Ordered | Given | Ordered | Given |
| Boostrix / Adacel | | | | | | | | |
| Boostrix IPV / Adacel IPV | | | | | | | | |
| ADT | | | | | | | | |
| Ipol | | | | | | | | |
| MMR | | | | | | | | |
| Flu Vax | | | | | | | | |
| Pneumovax | | | | | | | | |
| Dukoral (Cholera) | | | | | | | | |
| Typhoid - injection | | | | | | | | |
| Typhoid - oral | | | | | | | | |
| Hepatitis A – adult | | | | | | | | |
| Hepatitis A – child | | | | | | | | |
| Hepatitis B – adult | | | | | | | | |
| Hepatitis B – child | | | | | | | | |
| Twinrix – adult | | | | | | | | |
| Twinrix – child | | | | | | | | |
| Meningitis ACWY | | | | | | | | |
| Neiscvax | | | | | | | | |
| Yellow Fever | | | | | | | | |
| Japanese Encephalitis | | | | | | | | |
| Rabies | | | | | | | | |
| Tuberculosis | | | | | | | | |
| | | | | | | | | |
| Travel booklet | | | | | | | | |
| | | | | | | | | |
| | Doctors please initial when ordered | | | | Please initial when issued | | | |
| Specify quantity ordered | Ordered | Given | Ordered | Given | Ordered | Given | Ordered | Given |
| | | | | | | | | |
| Medications | | | | | | | | |
| Panadol | | | | | | | | |
| Gastrolyte | | | | | | | | |
| Imodium | | | | | | | | |
| Norfloxin | | | | | | | | |
| Keflex | | | | | | | | |
| Maxalon | | | | | | | | |
| Stemetil | | | | | | | | |
| Doxycycline | | | | | | | | |
| Malarone | | | | | | | | |
| Phenergan / Telfast | | | | | | | | |

| | Visit 1 | | Visit 2 | | Visit 3 | | Visit 4 | |
|---|---|---|---|---|---|---|---|---|
| Date | / / | | / / | | / / | | / / | |
| Cold & Flu medication | | | | | | | | |
| Buscopan | | | | | | | | |
| Temazapam | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Specify quantity ordered | Doctors please initial when ordered | | | | Please initial when issued | | | |
| Preventative Items | Ordered | Given | Ordered | Given | Ordered | Given | Ordered | Given |
| DEET insect repellant | | | | | | | | |
| Permethrin net | | | | | | | | |
| Water sterilizing agent | | | | | | | | |
| Sunscreen 30+ | | | | | | | | |
| Syringe kit | | | | | | | | |
| ID Bracelet | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Please bring all pages of this form to your travel consultation with your doctor

Dr…….. Date / /