FAMILY 5TH AVE PRACTICE
Your Family Doctor Cares

Travel Questionnaire

Personal Details

First Names _____ **Last Name** _____

Date of Birth dd / mm / yyyy **Age** _____ **Gender** Male / Female

Country of Birth _____ **Nationality** _____

Address _____ **Home Phone** _____

_____ **Mobile Phone** _____

Suburb _____ **Work Phone** _____

Town/City _____ **Email** _____

Emergency Contact Details _____

Regular GP _____ **Send Notes** Yes / No

Travel Details

Destinations

Country	Lenght of Stay	Planned Activities
	days	
	days	
	days	
	days	
	days	
	days	
	days	
	days	

Reasons for Travel

☐ Leisure ☐ Business ☐ Visiting friends and/or family ☐ Other: _____

Accommodation

☐ Backpackers ☐ Hostels ☐ Motels and/or hotels ☐ Air conditioned ☐ Camping

What modes of transport will you be travelling by: _____

Planned Activities

☐ Scuba diving ☐ Swimming ☐ Rafting ☐ Boating ☐ Mountain travel and/or trekking

☐ Cycling ☐ Other: _____

Have you travelled before? Yes / No **Where?** _____

Previous Travel Vaccinations

☐ Hepatitus A ☐ Heatitus B ☐ Typhoid ☐ JEV ☐ Rabies ☐ Meningococcal
☐ Yellow Fever ☐ Polio ☐ Tetanus

Have you had travel health problems before? Yes / No

If yes, please give details: _____

Have you had reactions to travel vaccinations before? Yes / No

If yes, please give details: _____

Medical History

Do you have or have you ever had any of the following medical or health conditions?

☐ Joint problems ☐ DVT/PE (blood clots) ☐ Psoriasis ☐ Bleeding disorders
☐ Mastectomy ☐ Splenectomy ☐ Epilepsy ☐ Hypertension
☐ Asthma/COPD ☐ Heart disease ☐ Chest problems ☐ Tuberculosis
☐ Diabetes ☐ Hepatitis (Yellow Jaundice)
☐ Stomach ulcers/heartburn/indigestion ☐ Immunity problems (HIV, cancer, chemotherapy)
☐ Other: _____

Have you had a blood transfusion/immunoglobulin in the past 12 months? Yes / No

Do you, or any of your family members, have a history of depressions, anxiety, phobias, or any physchiatric illness? Yes / No

Have you been admitted to a hospital in the past six months? Yes / No

Have you had or been advised to have any sugical operations? Yes / No

Are you currently taking or do you occassionally take any medications? Yes / No

Do you think you have missed any childhood vaccines? Yes / No
Such as DPT, Hep B, MMR, Polio, HIB.

Do you have any allergies or allergic reactions?

☐ Eggs ☐ Aluminium ☐ Insect bites ☐ Bandaids
☐ Antibiotics (e.g. tetracyclines, sulphur drugs, penicillin, neomycin)
☐ Other: _____

Female Patients

Are you pregnant or planning to become pregnant within three months after travelling? Yes / No

Are you breast feeding? Yes / No

Are you currently using any contraceptive medication? Yes / No

If yes, please give details: _____

Travel Concerns

Do you have any specific concerns about your travel? _____