August 2023

Torbay Travel Clinic
Don't Wing It

PRE-TRAVEL QUESTIONNAIRE FORM

Please bring COMPLETED QUESTIONNAIRE, TRAVEL ITINERARY and any VACCINE RECORDS with you to your appointment.

SECTION A TRAVELER INFORMATION

First Name: _____ Last name: _____

Date of Birth: ___/___/___ Age: _____ Gender: M / F Email address: _____

SECTION B TRAVEL ITINERARY

Departure Date: _____/_____/_____ Return Date: _____/_____/_____

Countries To Be Visited (In Order)	City or Region	Length of Stay (Days)
1.		
2.		
3.		

Accommodations: Hotel __ Hostel __ Family Home __ Cruise __ Camping __ Other: _____

Purpose of Trip: Holiday __ Business __ Visiting family/friends __ School trip __ Other: _____

Activities planned: Diving/Snorkeling __ Fresh water/Rafting __ Trekking __ Cycling __ Altitude __

Do you have any concerns over this trip? _____

Travelling to a High-Altitude Y/N (circle) Highest Altitude _____ Duration above 3000m_____

Are you travelling to a Malaria Zone Y/N If so, how many days _____

SECTION C MEDICAL HISTORY

Health Conditions:

Heart __ Blood Pressure __ Cholesterol __ Blood clots __ Blood Thinners __ Seizures __ Thymus/Splenectomy __

Skin Condition __ Diabetes __ Joint Problems __ Stomach Ulcers __ Epilepsy __ Weak Immune System __ HIV/AIDS__

Mental Illness __ Panic Attacks __ Organ/Bone Marrow Transplant __ Cancer __ Lung problems/Asthma __

Recent hospitalisation/ illness/ injury in the last 6 months? _____

Are you currently undergoing any medical treatment? _____

Allergies: Any medications __ Eggs __ Gelatine __ Iodine __ Latex __ Insect bites __ Other_____

Current Medications: _____

Women only: *Are you PREGNANT? Or trying to become pregnant/ nursing or within 3 months of your return? Yes/No*

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SECTION D IMMUNIZATION HISTORY & PLAN

Have you had all your childhood vaccines? Yes/No (circle)
Have you had any Previous Travel vaccines? _____

Advice Checklist
Food/water __ Insect avoidance __ Yellow Fever __ Rabies __ Altitude __ DVT __ Schistosomiasis __
Activity advice __ Personal safety/Insurance __ Drug interactions __ Sexual health __ Section 29 __

Recommended Vaccines			Recommended Vaccines		
Influenza (Flu)	$36		Hep A	$100	
Tetanus/Diphtheria/Pertussis	$62		Hep A Jnr	$67	
			Hep A/Typhoid	$160	
Diphtheria/Tetanus/Pertussis/Polio	$97		Hep B	$55	
Typhoid Injection	$90		Hep A/B	$100	
Typhoid capsules (3 capsules)	$70		Hep A/B Jnr	$70	
Rabies	$148		Polio	$87	
Yellow Fever	$126		Meningococcal	$140	
Japanese Encephalitis	$250		Cholera	$65	

YELLOW FEVER – have you read the CDC Yellow Fever vaccine information sheet Yes/No

SECTION E PATIENT CONSENT

1. **Are you currently sick or experiencing a high fever? Yes/No**
2. **Have you had any allergies or had a serious reaction to a vaccine in the past? Yes/No**
3. **Do you have any medical problems that makes it hard for you to fight infection? Yes/No**
4. **Have you recently had any other vaccination or blood products? Yes/No**
5. **Are you pregnant or thinking of becoming pregnant within the next 3 months? Yes/No**
6. **Are there any other concerns? Yes/No**

I have been fully informed regarding the requested vaccination/s and I have had a chance to ask questions.
I understand the benefits and risks of the vaccination/s, and request the vaccination be given to me, or the person named below for whom I am authorised to make this request.
I consent for the inclusion of this immunization data in the NIR (National Immunisation Register).

_____ _____ _____

Signature of Patient/Parent or Guardian Witnesses Date

The person being vaccinated agrees to remain in the building for 20 minutes after receiving the vaccination. Possible side effects include discomfort, aching, redness or lump at injection site. In rare severe cases the person receiving the vaccination may have a severe reaction and require medical intervention