PERTH VACCINATION & TRAVEL CENTRE: PRE-TRAVEL ASSESSMENT FORM

TO BE COMPLETED BY THE PATIENT

Salutation: Surname: ______________ First name: ______________

Appointment Date: ____ / ____ / ____ Appointment Time: ________ ☐ AM ☐ PM

Date of birth: ____ / ____ / ____ Occupation: ______________

Contact Number: ______________ Mobile Number: ______________

Address: ______________ Postcode: ______

Email Address: ______________

☐ YES I would like to receive regular travel updates.

I will pay by: ☐ Cash ☐ Eftpos ☐ Visa ☐ Mastercard ☐ AMEX

I have Private Health Extras cover: ☐ Yes ☐ No

I heard about the Perth Vaccination & Travel Centre from *(please tick and provide details where possible)* :

- ☐ Website ______________
- ☐ Travel Agent ______________
- ☐ Yellow pages
- ☐ White Pages
- ☐ GP ______________
- ☐ Signs
- ☐ Friend
- ☐ Other ______________

Personal Medical History

	YES	NO
Are you well today?	☐	☐
Is your general health good?	☐	☐
Have you ever fainted or felt unwell soon after an injection?	☐	☐
Have you ever had a serious reaction to a vaccine before?	☐	☐
Have you received any vaccines in the past month?	☐	☐
Are you currently on steroids?	☐	☐
Are you allergic to eggs, medication or other substances?	☐	☐
List allergies: ______________		
Have you received any blood products or had a blood transfusion in the past year?	☐	☐
Does someone with lowered immunity live at home with you?	☐	☐
Do you or any close family member have epilepsy?	☐	☐
Do you have any history of Guillian-Barre Syndrome?	☐	☐
Have you suffered from any of the following:		
Jaundice/Hepatitis	☐	☐
Blood clots/DVT	☐	☐
Ear/Hearing problems	☐	☐
Cancer/Radiotherapy/Chemotherapy	☐	☐
HIV/AIDS	☐	☐
Thymus disorder	☐	☐
Diabetes	☐	☐
Lung disease	☐	☐
Do you have any history of mental illness including depression/anxiety?	☐	☐
Please list all current medication: ______________		
Women Only: Are you pregnant, planning a pregnancy or currently breast feeding?	☐	☐

Vaccine History

Please indicate which year the following vaccines were given. Also indicate if you have had any of the diseases.

You can check with your G.P. or previous medical records to find this information.

Vaccine Given	Year
Tetanus / Diptheria / Pertussis (Whooping Cough)	
Tetanus / Diptheria	
Polio	
Measles / Mumps / Rubella	
Varicella (Chicken Pox)	
Hepatitis A	
Hepatitis B	
Hepatitis A / Typhoid	
Typhoid	
Yellow Fever	
Meningococcal	
Rabies	
Cholera	
Japanese Encephalitis	
Tick-Borne Encephalitis	
Q Fever	
Mantoux / BCG	
Pneumovax	
Influenza	
Other:	

Have you had anti-malarial tablets in the past?

Malarone	☐ Yes	☐ No
Doxycycline	☐ Yes	☐ No
Lariam	☐ Yes	☐ No
Other: ______________	☐ Yes	☐ No

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Please list all countries that you have previously visited:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

List all the countries to be visited in order of visits:	**Duration (days, weeks, months):**
1. ______________________	______________________
2. ______________________	______________________
3. ______________________	______________________
4. ______________________	______________________
5. ______________________	______________________
6. ______________________	______________________

Date of Departure: ______________________ **Length of Stay:** ______________________

Tick the following that applies to your trip:

Business Trip:

- ☐ Onshore
- ☐ Offshore
- ☐ Rig
- ☐ Vessel
- ☐ City
- ☐ Rural

Holiday:

- ☐ Package
- ☐ Self-organised
- ☐ City
- ☐ Rural
- ☐ Trekking
- ☐ Adventure
- ☐ Backpacking
- ☐ Camping
- ☐ Cruise
- ☐ Altitude
- ☐ Safari
- ☐ Other: ______________________

Accommodation:

- ☐ Hotel
- ☐ Friend
- ☐ Relative
- ☐ Other: ______________________

ɘ END OF PATIENT COMPLETION ɞ

Please return form to reception.