Pre- Travel Consult Questionnaire

Brisbane GP & Travel Doctor

Name: ______________________________ **DOB:** ___/___/_____

Part A: Details of the Trip

Departure Date: ____/____/______ **Total Length of Trip:** ________________

I will be visiting the following places:

Town	Country	City/Rural	Accommodation Type (hostels, hotels etc)	No. Days	Special Considerations	Type of Trip (bus/tour/backpack/cruise)

Will you be undertaking any special adventure activities? *(please circle)*

Scuba Diving / Cycling / Cave Exploration / Trekking / Mountain Climbing / Safari

Other (please specify): ____

Part B: Vaccination Record

1. Did you receive all your childhood/school vaccinations: YES / NO
2. Have you had any of the following vaccines previously? (please tick)

Vaccine	Yes	No	Year/s	Vaccine	Yes	No	Year/s
Tetanus/Diptheria				*Pneumonia*			
Measles/Mumps/Rubella				*Meningitis*			
Polio				*Yellow Fever*			
Hepatitis A				*Rabies*			
Hepatitis B				*Typhoid (oral/injection)*			
Influenza				*Other:*			

Part C: Health Issues which may affect your Travel or Vaccinations

1. Have you had any health problems on previous trips overseas? YES / NO

   If you are a regular patient at our clinic please skip to question 8
2. Do you have or have you had any of the following medical conditions? (Please Tick)

Medical Condition	Yes	No	Medical Condition	Yes	No
Heart Disease			*Hepatitis A*		
Irregular Heart Beat			*Thymus Disease*		
High Blood Pressure			*Bleeding Disorders*		
Respitory Problems			*HIV/ Aids*		
Asthma			*Cancer*		
Diabetes			*Splenectomy*		
Epilepsy			*Depression/Anxiety*		
Stomach Ulcer			*Psoriasis*		
Psychiatric Problems			*Inflammatory Bowel Disease*		

Other: Please Specify: ____

3. List any other major surgery you have had (e.g: open heart surgery):
   ____
   ____
   ____

4. Have you had any illness or injury in the last 6 weeks requiring medical attention? YES / NO

5. Have you recently undergone radiotherapy, chemotherapy or steroid treatment? YES / NO

6. List all your current medications including oral contraceptive:
   ____
   ____
   ____

7. Are you allergic to: Medication / Food / Eggs / Other (please circle)
   If Yes, please specify: ____

8. Have you ever felt faint or fainted after having an injection? YES / NO

9. Have you had a serious reaction to a vaccine in the past? YES / NO

10. Have you had any of the following vaccines in the past 3 weeks?
    Yellow fever / Tuberculosis / MMR / Varicella (YES / NO)

11. Do you have any health concerns regarding this trip? YES / NO

For Women:

12. Are you pregnant, breast feeding, or planning a pregnancy within the next 3 months?
    YES / NO

Thank you for completing this form
Please provide this completed form at the time or your consultation.
Alternatively, you may email back to the clinic at: admin@brisbanegp.com.au