You

First Name _____ Last Name _____

Age _____ Date of Birth _____

Sex ☐ Male ☐ Female ☐ Gender Diverse (please state) _____

Ethnicity _____ Country of Birth _____

Current Address _____ Suburb/City _____

Country _____

Permanent Address (if different from above) _____

Suburb/City _____ Country _____

Phone Number

Home_____ Work _____ Mobile _____

Occupation _____ Company/Organisation _____

Registered GP Name _____ GP Practice Name _____

Notes to be sent to GP? ☐ **Yes** ☐ **No**

NOK Contact Person _____ NOK Address _____

NOK Phone Number _____ NOK Relationship _____

Current Smoking Status

Smoking is an important factor influencing health If you are aged 15 and over please tick the space that applies for you

- ☐ Currently smoke
- ☐ Recently quit
- ☐ Ex-smoker (over 1 year)
- ☐ Never smoked

Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.

If you currently smoke, would you like some help to quit?

☐ **Yes** ☐ **No**

Travel insurance ☐ **YES** ☐ **NO**

Countries travelled in the last 3 years _____

Your Health

1	Have you travelled to less developed countries before *Did you have health problems while away?*	□ Yes | □No	1
2	Do you have or have you ever had any medical problems? Please CIRCLE any that apply: blood clots, asthma, chest problems, heart disease, high blood pressure, diabetes, stomach ulcer, psoriasis, joint problems, cancer mastectomy, splenectomy, epilepsy, depression, schizophrenia, anxiety attacks, mental illness, weakness of the immune system, HIV/AIDS, thymus disorders? *If not listed please specify here:*	□ Yes | □No	2
3	Do you have a family history of blood clots, depression, schizophrenia, anxiety attacks or mental illness? *If yes, please specify*	□ Yes | □No	3
4	Are you taking an regular medication (both prescription & non-prescription) e.g. the contraceptive pill, vitamins or do you occasionally take medication e.g. migraine tablets, Ventolin? *Name of all medications*	□ Yes | □No	6
5	Are you allergic to anything? e.g. sulphur drugs, penicillin, tetracycline's, neomycin, mercury/thiomersal, gelatine, eggs, iodine, latex, Band-Aids, insect bites? *If yes, please specify*	□ Yes | □No	7
6	Have you been in hospital, been ill or injured in the last six weeks?	□ Yes | □No	4
7	Have you had immune globulin or a blood transfusion in the last twelve (12) months	□ Yes | □No	5
8	Have you ever felt faint or fainted after an injection or giving blood?	□ Yes | □No	8
9	Woman Only: Are you pregnant or planning to become pregnant while travelling or within three (3) months of your return?	□ Yes | □No	9
10	Did you miss any of the usual childhood vaccines?	□ Yes | □No	10
11	Do you have any particular health concerns regarding this trip?	□ Yes | □No	11

Your Trip

12 Any concerns you would like to address? Please check list below:

□ Personal First Aid Kit □ Managing motion sickness □ Avoiding altitude sickness

□ Safe Sex while travelling □ Travelling with children □ Managing diarrhoea

□ Minimising jet lag □ Water & Food safety □ Minimising Travel anxiety

□ Travel Insurance □ Infection risk □ DVT Prevention □ Personal Saftety

□ Mosquito borne conditions/prevention

13 Please list in order the countries you intend visiting, and how long (in weeks) you plan to spend in each:

i. _____ ( ) weeks Drs Use only _____

ii. _____ ( ) weeks _____

iii. _____ ( ) weeks _____

iv. _____ ( ) weeks _____

v. _____ ( ) weeks _____

vi. _____ ( ) weeks _____

vii. ( ) weeks

_____ _____

What is the main purpose of your trip?

□ Holiday □ Visiting family/friends □ Business Trip

□ Other

14 Type of accommodation?

□ Camping □ Budget □ Air-conditioned hotel □ Private Home

□ Other

15 Planned activities

□ Trekking/Altitude □ Scuba Diving □ Cycling □ Rafting/Boating

□ Other

16 Date leaving New Zealand _____

17 Return date to New Zealand _____

Other

18 How did you learn of Northcare Travel Clinic? _____

How will you be paying for your visit?

□ EFTPOS □ Cash □ Credit Card □ Company Account

Signature: Date:

_____ _____

Thank you!

NorthCare
Travel Clinic

First Name _____ **Last Name** _____ **Age** _____

CLINIC USE ONLY

Date:			**Visit 1**	**Visit 2**	**Visit 3**	**Visit 4**	**Visit 5**
Disease	PHx	Vaccine					
Polio							
Tet/Dip/DTaP							
MMR							
Varicella							
Flu							
Pneumonia							
Typhoid							
Hep A							
Hep A / Typhoid							
Hep B							
Hep A / Hep B							
Meningitis (ACWY)							
Yellow Fever							
Cholera							
Jap. Enceph.							
Rabies ID IM							
BCG (Scar/No Scar)							
Mantoux / Quantaferon Gold							
RN signature							
Malaria Chemoprophylaxis / Doxy / Lariam / Malarone / Chloroquine							
Medical Kit							

Advice Check List

☐	Food / Water	☐	Insect avoidance
☐	DVT risk / prevention	☐	Woman's health
☐	Sexual health	☐	Personal safety / insurance
☐	Drug interactions	☐	Activity advice – Altitude
☐	Activity advice – Diving	☐	Activity advice – Cycling
☐	Activity advice – Rafting / Water	☐	Activity advice –Other
☐	Yellow book	☐	Section 29
☐	Well Child book copied	☐	IHG

Doctors signature _____