# Taupō Health Centre

**Email: admin@taupohealth.co.nz**

**113 Te Heuheu Street, Taupō**

**07 378 7060**

## PRE- TRAVEL QUESTIONNAIRE

Please add as much detail to this form as possible as this will ensure that the best advice is given for your travel.
Drop this form and your itinerary to reception. We will call you direct re: appointments and vaccinations.

**Travel Health Risk Assessment Form – Adults or under 18 years travelling alone.**

**Personal details**

Name:

_____

Date of Birth: Male [ ] Female [ ]

_____

Easiest contact telephone number:

_____

Email:

_____

GP name and address if not enrolled at this medical practice:

_____

**Date of departure:** **Overall length of trip:**
**Countries you transit through:**

| **Itinerary and purpose of visit** | | | |
|---|---|---|---|
| **Country to be visited** | **Length of stay** | **Names of major cities** | **Visiting country side** |
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |
| **6.** | | | |

| **Patient Name:** | **Date of Birth:** |
|---|---|

**Please circle the descriptions that best describes your trip**

| | | | | | |
|---|---|---|---|---|---|
| **1. Type of trip** | Business | | Holiday | Visiting Family/Friends | |
| **2. Holiday type** | Package<br>Camping | | Self organised<br>Cruise ship | Backpacking<br>Trekking | |
| **3. Accommodation** | Hotel/Motel | | Relatives/Family home | Other…….. | |
| **4. Travelling** | Alone | | With family/friend | In a group | |
| **5. Staying in area which is** | Urban | | Rural | Altitude | |
| **6. Planned activities** | Safari | Hiking | Diving | Cycling | Motorbiking |

**Personal medical history**

List any current or regular medications.
Comments_____

Do you have any **ALLERGIES**, for example to eggs, antibiotics, nuts, bees, medications?
Comments_____

Have you ever had a serious reaction to a vaccine given to you before?
Comments_____

Do you have any history of mental illness, including depression or anxiety?
Comments_____

Please tick if you have or ever had any of the following medical conditions:

- ☐ Asthma
- ☐ Heart problems
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Mental Illness
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Kidney problems
- ☐ Altitude sickness
- ☐ Epilepsy
- ☐ Blood/bleeding disorder
- ☐ Liver problem
- ☐ Skin conditions
- ☐ Removal of spleen
- ☐ Blood clot in leg/deep vein thrombosis
- ☐ Decompression sickness/The bends
- ☐ Immune system problems
- ☐ Lung disease
- ☐ Any operations or hospital admissions in last 12 months

Please give further details in the space below if you have ticked any of the conditions listed above

_____
_____
_____

Have your recently undergone radiotherapy, chemotherapy or steroid treatment?

_____

Woman only: Are you pregnant, planning pregnancy, breastfeeding or on contraception?

_____

| |
|---|
| |

| **Patient Name:** | **Date of Birth:** |
|---|---|
| | |

Have you taken out travel insurance? If you have a medical condition, have you informed the insurance company of this?

_____

Please give any further information that may seem relevant, including any future travel plans

_____

_____

**Vaccination History**

Have you ever had any of the following vaccinations/malaria tablets, and if so, when?

| | | |
|---|---|---|
| ☐ Tetanus/Diphtheria | ☐ Polio | ☐ MMR |
| ☐ Typhoid | ☐ Hepatitis A | ☐ Hepatitis B |
| ☐ Meningitis | ☐ Yellow Fever | ☐ Influenza |
| ☐ Rabies | ☐ Jap Enceph | ☐ Cholera |
| ☐ Malaria | ☐ Full course childhood vaccinations | |

Other

_____

Pregnant Yes ☐ No ☐

_____

Do you have any particular concerns or questions you would like to ask regarding this trip?

*PLEASE ATTACH A COPY OF YOUR ITINERARY

| | |
|---|---|
| Signed: | Date: |

**For official use**

| | |
|---|---|
| **Patient Name:**<br>Travel risk assessment performed [ ] Yes [ ] No | Authorising Doctor……..<br>Authorisation for Nurse to administer vaccinations<br>Signed…… |

**Travel vaccines recommended for this trip**

| Disease Protection | Date | Further Information | Recommended | Day0 | Day7 | Day21 | Day28 |
|---|---|---|---|---|---|---|---|
| Hepatitis A | | | | | | | |
| Hepatitis B | | | | | | | |
| Typhoid | | | | | | | |
| Hep A/Typhoid | | | | | | | |
| Tetanus/Diphtheria (ADT) | | | | | | | |
| MMR | | | | | | | |
| Polio | | | | | | | |
| Meningitis ACWY | | | | | | | |
| Yellow Fever | | | | | | | |
| Rabies | | | | | | | |
| Japanese B Encephalitis | | | | | | | |
| Varicella | | | | | | | |
| Influenza | | | | | | | |
| Boostrix (dTap) | | | | | | | |
| Pneumococcal (PCV) | | | | | | | |
| Cholera/ETEC | | | | | | | |

Other **Travel Record Card Supplied** ☐

**Travel advice and/or leaflets given as per travel protocol**

| | | |
|---|---|---|
| ☐ Rabies | ☐ Air travel/DVT | ☐ Cruise ship travel |
| ☐ Insect bite prevention | ☐ Altitude sickness | ☐ Mental health |
| ☐ Sun and heat protection | ☐ Insurance | ☐ General AB |
| ☐ Malaria | ☐ Travellers diarrhoea | ☐ Yellow fever |
| ☐ Accidents/safety | ☐ Hajj travel | ☐ STI |
| ☐ Hepatitis B, C and HIV | ☐ Food, water and personal hygiene advice | |
| ☐ Antibiotic for TD/anti-diarrhoea | | |

☐ Other_____

Nurse Signature: _____ Date: _____

**Malaria prevention advice and malaria chemoprophylaxis**

☐ Atovaquone + proguanil (Malarone) ☐ Chloroquine ☐ Mefloquine ☐ Doxycycline