Pre-Travel Health Questionnaire

SECTION 1: PATIENT DETAILS			
Surname:		First names:	
Date of birth: / /	Male: ☐	Female: ☐	Other:
Country of birth:		Ethnicity:	
Address:			
City:			Postcode:
Home Phone:	Mobile:	Email:	
Usual GP/Medical Centre:		Consent to send record of vaccines? Yes ☐ No ☐	

SECTION 2: MEDICAL HISTORY & PREVIOUS TRAVEL	YES	NO
Are you currently experiencing any health issues or symptoms? (eg. fever, gastrointestinal, mental health)	☐	☐
If yes, please specify:		
Are you currently receiving any medical intervention, treatment or currently awaiting results?	☐	☐
If yes, please specify:		
Are you living with a disability, or have any mobility or accessibility needs?	☐	☐
If yes, please specify:		
Have you experienced illness during previous international travel?	☐	☐
If yes, please specify:		
Have you received any vaccinations in the past 4 weeks?	☐	☐
If yes, please specify:		
Have you ever had a serious allergic reaction to a vaccine?	☐	☐
If yes, please specify:		
Are you breastfeeding, currently pregnant or planning to become pregnant? Est. delivery date (if applicable):	☐	☐
Have you ever had hepatitis?	☐	☐
Have you had immune globulin or a blood transfusion in the last 12 months?	☐	☐
Have you ever taken anti-malarial medication? (eg. doxycycline, malarone, lariam)	☐	☐
If yes, what type, and did you experience any issues?:		
Do you have a history of blood clots?	☐	☐
For all casual/new patients, please complete this section. If you are an enrolled patient, please skip to section 4		
Do you have any medical problems? (eg. diabetes, heart disease, respiratory problems, HIV/AIDs, splenectomy, thymus disorder, etc.)	☐	☐
If yes, please specify:		
Are you currently taking any medication? (prescribed or not prescribed, eg. contraception, etc) Please list all regular medications, supplements and recreational drugs below	☐	☐
If yes, please specify:		
Do you have any allergies? (eg. drug allergies, sulphur, penicillin, any foods including eggs, etc)	☐	☐
If yes, please specify:		

SECTION 3: TRAVEL ITINERARY

Date of departure (New Zealand): / /	Total length of trip:
Date of return (New Zealand): / /	Do you have travel insurance? Yes: ☐ No: ☐
What is the type of travel/purpose of your trip? (eg. holiday, business, visiting friends/family, volunteer work, healthcare worker, backpacking, cruise, pilgrimage, medical treatment or health intervention: dental/cosmetic)	
Type of accommodation? (e.g. backpackers, hotels/Airbnb, staying with family, etc)	
Mode/s of travel? (e.g. car, motorbike, scooter, boat, etc)	
Planned activities? (e.g. diving, trekking, climbing, rafting, water sports, etc)	
Do you plan to visit rural/remote regions?	
Are you travelling with children or elderly individuals who may have specific health needs?	
Itinerary (please attach a travel itnerary or complete the information below)	
Country 1 (city, country)	Country 2
Country 3	Country 4
Country 5	Country 6

Are there any specific issues you wish to discuss in your appointment?

Malaria advice: ☐	Altitude sickness: ☐	Jet lag/air travel: ☐	Mosquito protection: ☐	Medical first aid kit: ☐
Other:				

SECTION 4: VACCINATION HISTORY

Routine vaccination	Yes	No	Date/s	Travel vaccination	Yes	No	Date/s
Tetanus/diphtheria/pertussis If yes, # of doses:				Hepatitis A If yes, # of doses:			
MMR (measles, mumps, rubella) If yes, # of doses:				Typhoid IM: Oral: # of doses:			
Hepatitis B If yes, # of doses:				Rabies If yes, # of doses IM ☐ ID ☐			
Influenza				Meningococcal/meningitis			
Pneumococcal vaccine				Japanese Encephalitis			
Meningococcal vaccine				JESPECT ☐ Imojev ☐			
Polio				Cholera/Dukoral			
COVID-19				Yellow fever			
Mpox				Other:			

To the best of your knowledge, have you received all routine childhood immunisations? Yes ☐ No ☐ Unsure ☐

CLINIC USE ONLY: AIR status checked ☐

Patient signature:	**Date: / /**
Parent/guardian signature (if applicable):	**Date: / /**

VACCINATION PLAN (once administered, enter into AIR) CLINIC USE ONLY

Disease/Vaccine	Rx or SO?		First visit	Second visit	Third visit	Fourth visit
	Rx	SO	Date: / /	Date: / /	Date: / /	Date: / /
Cholera/ETEC						
Hepatitis A						
Hepatitis A + B						
Hepatitis B						
HPV Gardasil						
Influenza						
J. Encephalitis JESPECT ☐ Imojev ☐						
Meningitis ACWY						
Meningococcal B						
MMR						
Pneumococcal						
Polio						
Rabies IM ☐ ID ☐						
Tdap						
Typhoid: oral ☐ IM ☐						
Varicella						
Yellow Fever						
Other:						

Advice checklist			Extras:		
Topic	Date	Pamphlet provided?	Provision	Provided	Date
Travel insurance	/ /	☐	Medical kit	☐	/ /
Personal safety	/ /	☐	Medication	☐	/ /
Mosquito avoidance	/ /	☐	Antimalarials	☐	/ /
Traveller's diarrhoea	/ /	☐	Acetazolamide	☐	/ /
Food/water safety	/ /	☐	Diarrhoea medication	☐	/ /
Animal bites	/ /	☐	Rx & print out of Rx	☐	/ /
DVT risk/prevention	/ /	☐	Vaccine record/book	☐	/ /
Sexual health	/ /	☐			
Altitude	/ /	☐	Doctor signature		
Activity advice	/ /	☐	RN signature		

Consent to vaccinate

I _____ consent to receiving the vaccinations as recommended on this document. The known risks associated with administration of these vaccines have been discussed with me, and the possibility of a rare adverse event or vaccine failure has been explained to me. I understand I need to remain in the clinic for 15–30 minutes following my vaccinations.

Patient Name: **Guardian Name (if applicable):**	**Signature:** **Date: / /**