Courtenay Medical

TRAVEL QUESTIONNAIRE

Surname:		**First name**:	
DOB:	**Age**:	**M/F**	**NHI:**
Country of Birth:		**Nationality**:	
Address:		**Phone no: (Home)**	
		Mobile:	
Postcode:		**Email:**	
GP name and Medical Centre:			
Would you like a copy of the notes to be sent to your GP?			
How did you hear about Courtenay Medical's travel clinic?			
Please complete questions below:			

1	Have you travelled previously to any developing countries?	**Yes**	**No**
	If **yes**: Did you have any health problems while away?	**Yes**	**No**
	If **yes** please specify:		
2	Do **you** have or **have you ever had any** medical problems? E.g. 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, or thyroid disorders?	**Yes**	**No**
	If **yes** please specify:		
3	Do you have **family** history of blood clots, depression, schizophrenia, anxiety attacks or mental illness?	**Yes**	**No**
	If **yes** please specify:		
4	Do you **regularly** take or **occasionally** take any medications? (prescription and non-prescription)	**Yes**	**No**
	Name of medications:		
5	Are you allergic to anything? E.g. sulphur drugs, penicillin, tetracyclines, neomycin, gelatine, any foods including eggs, iodine, latex, band aids, insect bites?	**Yes**	**No**
	If **yes** please specify:		
6	Have you been in hospital, been ill or injured in the last 6 weeks?	**Yes**	**No**
7	Are you currently undergoing any medical investigations/treatments?	**Yes**	**No**
	If **yes** please specify:		
8	Have you had immune globulin or a blood transfusion in the last 12 months?	**Yes**	**No**
9	**Women only**: Are you pregnant or planning to become pregnant while travelling or within 3 months of you return?	**Yes**	**No**
10	Are you up to date with your childhood vaccines?	**Yes**	**No**
11	Have you received any vaccinations during the past four weeks?	**Yes**	**No**
12	Have you ever had a serious reaction to a vaccination	**Yes**	**No**
13	Do you have any particular health concerns regarding this trip?	**Yes**	**No**
	Please outline:		
14	What is the purpose of your trip?		
15	**Date Leaving NZ:**	**Date Returning to NZ:**	
16	Please list in order the countries you intend visiting, and how long you plan to spend in each:		

1.	(days)	2.	(days)
3.	(days)	4.	(days)
5.	(days)	6.	(days)

Please note: A deposit of $50 is required to be paid at this point

Failure to attend the appointment will forfeit the deposit

Payment should be made to: 021269 0028940 00
Please use the reference Travel and include your full name

For non CMED patients only:

We would appreciate it if you can provide your complete immunisation history and list any previous travel vaccinations you have had below. This will help us determine what you may need for your trip	
Date Given:	**Vaccination:**

For Office use only:

Deposit paid: Yes / No

Date of travel	**Vaccines required**	**Cost** (estimate as dependant on vaccines required)	**Date of appointment**