familydoctor.melbourne
AND TRAVEL MEDICINE

Knoxfield and Colchester Medical Centres

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About You

Surname: _____ First Name _____

Sex: ☐ M ☐ F Date of Birth: _____/_____/_____

Address: _____

Phone: H: _____ W: _____ M: _____

Email: _____@_____

Nationality: _____ Country of Birth: _____

Occupation: _____ Employer: _____

Do you have private Health Insurance with Extras? ☐ Yes ☐ No If yes, who with: _____

Do you want a copy of your vaccination record sent to your Doctor? ☐ Yes ☐ No

If yes, our Doctors Name and Address: _____

_____

Your Health

1. (a) Have you travelled to developing countries before? ☐ Yes ☐ No

   (b) Did you have any health problems while away? ☐ Yes ☐ No

2. (a) Do you have or have you had any of the following medical problems:

☐ Asthma	☐ Chronic Lung Disease	☐ Thymectomy
☐ Stomach Ulcer	☐ Heart Disease	☐ High Blood Pressure
☐ Epilepsy	☐ Depression	☐ Splenectomy
☐ Irregular Heartbeat	☐ Blood Clotting Disorders	☐ Anxiety/Panic Attacks
☐ Diabetes	☐ Tendency to Chest Infections	☐ Mastectomy
☐ Psoriasis	☐ Joint Problems	☐ Venous Thrombosis
☐ Mental Illness	☐ Schizophrenia	☐ HIV/AIDS

   (b) Any other medical problems: _____

   (c) Do you have a family history of blood clotting disorder, clots in the leg veins or lungs (pulmonary embolus)? ☐ Yes ☐ No

3. Have you been in hospital in the last 6 weeks? ☐ Yes ☐ No
4. Have you ever had the disease Hepatitis A (Yellow Jaundice)? ☐ Yes ☐ No
5. (a) List any medication you are taking now (contraceptive pills, antibiotics): _____

   _____

   (b) List any medication you occasionally take (migraine tablets, ventolin, vitamins): _____

   _____

6. Are you allergic to any of the following:

☐ Eggs	☐ Bee Stings	☐ Sulphur Drugs	☐ Penicillin
☐ Iodine	☐ Latex	☐ Bandaid's	☐ Other: _____

7. Have you ever felt faint or fainted after an injection or giving blood? ☐ Yes ☐ No
8. (a) **Women Only:** Could you be pregnant now ☐ Yes ☐ No

   (b) Or do you plan to become pregnant within 3 months of your return? ☐ Yes ☐ No
9. Are you in contact with anyone with a weakened immune system (ie. AIDS, cancer sufferers on chemotherapy, people taking steroid drugs) ☐ Yes ☐ No
10. Did you miss any of the usual childhood vaccines? ☐ Yes ☐ No
11. Please outline any particular health concerns regarding this trip? _____

    _____

Your Trip

12. List dates for leaving:

    Home: _____ Australia: _____ Returning to Australia: _____

13. Place of Departure from Australia: _____

14. What is the main purpose of your trip?

    ☐ Holiday ☐ Visiting Family ☐ Business Trip ☐ Other _____

15. Type of Accommodation:

    ☐ Camping ☐ Budget ☐ Hotel with Aircon ☐ Private Home ☐ Other _____

16. Will you be doing any adventure activities?

    ☐ Trekking ☐ Scuba Diving ☐ Climbing ☐ Other _____

17. Who will you be travelling with:

    ☐ Solo ☐ Organised Tour ☐ Another person/s

18. Please list in order the countries you intend visiting, and how long (in days) you plant to spend in each:

    _____ _____ days _____
    _____ _____ days _____
    _____ _____ days _____
    _____ _____ days _____
    _____ _____ days _____
    _____ _____ days _____

Other

19. How did you hear about our travel clinic: _____

20. How will you be paying for your visit today? _____

Signed: _____ Date: _____/_____/_____

Surname: _____ **First Name** _____

Consultation	**$**
GST	**$**
IPOL/dTpa	$
IPOL	$
ADT/Boostrix/Adacel	$
Rotavirus	$
HIMMRB	$
Varicella	$
Fluvax	$
Pneumonia	$
Meningitis (Specify)	$
Yellow Fever	$
Vivaxim	$
Typhim VI	$
Vivotif (1Cap)	$
Hep A Vq50/HV1440/Avax	$
Hep A Vaqta 25 (Junior)/Havrix 720	$
Hep B HB Vax II Adult/Engerix Adult	$
Hep B HB Vax II Paed/Engerix Paed	$
Twinrix Adult Junior	$
Jespect/Imojev	$
Rabies IMI	$
Rabies ID	$
Mantoux Group/Individual	$
BCG	$
Dukoral	$
HPV	$
Plaquenil x 20 or x 100	$
Docycycline x 7	$
Lariam (Mefloquine) x 1	$
Malarone x 12	$
Paludrine (Proguanil) x 100	$
Ondansetron	$
First Aid Kit (specify)	$
Medical Kit (specify)	$
Shaprz Kit	$
Digital Thermometer	$
Permethrin Kit	$
Acetazolamide (Diamox)	$
Hydralyte	$
Loperamide	$
Norfloxacin	$
Roxithromycin x 5	$
Prochlorperazine	$
Temazepam x 25	$
Tinidazole (Simplotan) x 4	$
Azithromycin	$
Repellent	$
Sunscreen	$
Moquito Net	$
Total Cost	**$**

Date of Service: _____/_____/_____

Medical Notes:

For corporate Medical Assessments

ECG		Other		
Spiro				
Audio				
CXR				
D & A				
Path				

Consent to Vaccinate:

I _____ consent to myself or my dependant _____ receiving the vaccinations as prescribed in 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. Approximate costs have been indicated to me. I understand I may need to remain at the Clinic for 15 - 30 minutes following my vaccinations.

Signed: _____ (Patient)

Date: _____/_____/_____

Signed:_____ (Witness)

Date: _____/_____/_____