

Travel Medicine Centre Perth

Health Plan GP Assist Service

GENERAL PRACTITIONER DETAILS

NAME:	FAX:	PHONE:
PRACTICE ADDRESS:		

TRAVELLER'S DETAILS

GIVEN NAME:	SURNAME:		
SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DOB / /	OCCUPATION:	
CONTACT PHONE #:			

YOUR PAST HEALTH

Do you have any ongoing medical problems? (eg: asthma, diabetes, psoriasis, high blood pressure, stomach ulcer, joint problems, anxiety, depression, chest infections, epilepsy or recurrent thrush) _____ Yes No
 If Yes, please specify: _____

Have you ever had anxiety, depression, epilepsy, a mastectomy, splenectomy or any other serious medical problems? _____ Yes No
 If Yes, please specify: _____

Have you been a patient in a hospital in the last 6 weeks? _____ Yes No

Have you ever had Hepatitis A infection (yellow jaundice)? _____ Yes No

Do you take any **regular** medication? (eg. contraceptive pill, heart tablets etc) _____ Yes No
 If Yes, please specify: _____

Are you currently on any other medications? _____ Yes No

Are you allergic to anything? (Eggs, Iodine, Bee stings, Sulphur drugs, Penicillin, Latex, Band-aids) _____ Yes No
 If Yes, please specify: _____

Are you prone to fainting after an injection or giving blood? _____ Yes No

Are you breast feeding, pregnant or planning to become so within the next three months or while on your trip? _____ Yes No

Do you or anyone you are in contact with have a poor immune system? (eg: AIDS, Cancer, Leukaemia, Newborns) _____ Yes No

Have you had any vaccinations in the past month? (eg: cholera, polio etc) _____ Yes No

YOUR TRIP

Please list in order the countries that you intend visiting and how long you will spend in each:

1			wks	5			wks
2			wks	6			wks
3			wks	7			wks
4			wks	8			wks

Date leaving Perth: _____ Place of Departure from Australia: _____

Date leaving Australia: _____ Return Date to Australia: _____

Is this your first overseas trip? Yes No If No, how many previous overseas trips?

What is your main reason for travel? Relaxation Adventure Work
If participating in adventure activities please specify:

Approximately what percentage of your time will be in:

Rural/Remote Areas _____% Urban/Resort Areas _____% Above 1000 meters altitude
_____%

Main type of Accommodation?

4-5 Star Hotels

Intermediate
(2-3 Star, Work Site etc)

Basic
(Backpacking, Camping)

How did you hear of this clinic?

Travel Agent/Airline – Name of Travel Agent _____

Friend/Relative Other (please specify) _____

Once you have completed all of the questions please fax or post this form, along with your \$16.50 payment to:

Travel Medicine Centre Perth Ground Floor 5 Mill Street Perth WA 6000 Fax 08 9321 0899			
Please forward your credit card details if this is your payment option:	VISA	MASTERCARD	BANKCARD
Card Number: _____		Expiry Date: _____	
Card Holders Signature: _____			