Travel Medicine Centre Perth

Health Plan GP Assist Service

GENERAL PRACTITIONER DETAILS

NAME:	**FAX:**	**PHONE:**
PRACTICE ADDRESS:		

TRAVELLERS DETAILS

GIVEN NAME:	SURNAME:	
SEX ☐ FEMALE ☐ 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, Bandaids)__ ☐ 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: