

BALLARAT MEDICAL CENTRE

PRE-TRAVEL ASSESSMENT



Mr / Mrs / Ms / Dr / Miss Surname

First Name

Date of birth / /

Occupation

Contact details for the next 1- 2 years:

MOBILE:

HOME PHONE:

Address

Postcode

Medicare Number.....

Expiry Date..... Reference No.....

Will you be paying by: CASH ☐ EFTPOS ☐ CHEQUE ☐

If your visits are being paid for by your employer please provide contact details: (Name, Address etc.)

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How did you hear about us? (Please Circle)

	Friend/ Relative	TCA Website	Travel Agent	Doctor	bmc Website	Work Colleague	Other
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Surname:Given Name(s):.....

Regular GP:.....

GP's Address.....

Would you like the practice to notify your GP of vaccinations given? YES / NO (please circle)

PART 1

ALL PATIENTS MUST COMPLETE PART 1

Date of Departure:

Date of Return:

Countries to be visited	Cities or areas to be visited	Length of Stay

Please circle all the descriptions that describe your trip:

Type of Trip:	Business	Pleasure	Other			
Holiday Type:	Package	Self-Organised	Backpacking	Trekking	Camping	Cruise Ship
Accommodation:	Hotel	Relatives	Hostel	Other		
Travelling:	Alone	With Family	In a Group	Friend/s	Colleague	
Staying in Area:	Urban	Rural	Altitude			
Activities:	Safari	Adventure	Other			

Surname:..... Given Name(s):.....

PART 2

YOUR HEALTH – Current OR Past:

Please List any Medications that you are currently taking:

Do you OR have you had any of the following medical problems (*Please circle*)

Asthma	Diabetes	High Blood Pressure	Leukaemia
HIV/AIDS	Irregular Heartbeat	Splenectomy	Epilepsy
Heart Disease	Blood Clotting Disorder	Weakness of the Immune System	Transplant
Recent Chemotherapy / Radiotherapy			

A. Any other Medical Problems? :

B. Are you allergic to any of the following:

Eggs	Penicillin	Iodine
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Do you have any other Allergies?:

C. Have you ever felt faint or fainted after an injection or giving blood? : Yes / No

D. (Women only) Could you be, or are you planning to become pregnant within 3 months of your return? :
Yes / No

E. Are you in contact with anyone with a weakened immune system? : Yes / No

F. Have you ever had a serious reaction to a vaccine give to you before? : Yes / No

G. Have you ever taken Malaria tablets? Name:

PREVIOUS TRAVEL PATIENTS PLEASE RECORD VACCINATIONS GIVEN ELSEWHERE SINCE YOUR LAST VISIT TO OUR CLINIC.

PART 3

Vaccination History – Please write the date next to vaccine:

Tetanus	Whooping Cough / Tetanus	Polio
Influenza	Hepatitis A	Hepatitis B
Rabies	Yellow Fever	Measles, Mumps, Rubella
Japanese Encephalitis	Typhoid	Varicella (Chicken Pox)