TRAVEL ASSESSMENT

Ochre MEDICAL CENTRE Wollongong

YOUR DETAILS

Title	
Surname	
Given Names	
Date of Birth	
Gender	

DO YOU HAVE ANY OF THE FOLLOWING DISEASES?

Hepatitis	Yes / No
Organ Transplant	Yes / No
HIV / AIDS	Yes / No
Deep vein thrombosis (DVT) or blood clots	Yes / No
Leukaemia, lymphoma or other cancer	Yes / No

VACCINATION HISTORY

Indicate whether you have had the following vaccines, the approximate year received and any adverse reactions.
Check with your GP or previous medical records to find this information.

Vaccine	Year	Adverse reactions or comments
BCG		
Cholera		
Hepatitis A		
Hepatitis B		
Influenza (seasonal or H1N1)		
Japanese Encephalitis		
Measles / Mumps / Rubella		
Meningococcal		
Pneuomococcal		
Polio		
Q Fever		
Rabies		
Tetanus / Diptheria / Pertussis		
Typhoid		
Varicella (chicken pox)		
Yellow Fever		

Have you ever fainted or felt unwell soon after an injection?	Yes / No
Are you pregnant or trying to become pregnant?	Yes / No
Are you breastfeeding?	Yes / No
Have you ever been tested for TB? (Mantoux test, Quantiferon)	Yes / No
Have you previously received anti-malerial drugs?	Yes / No

If yes, provide details of drug taken, duration and any adverse reactions

COMMENTS

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