



Mornington
Medical Group

Pre-Travel Assessment Form

Please complete and return to reception

Section 1 — Personal Details

Title | Mr | Mrs | Master | Miss | Dr |

Given Name

Address

Home Phone

Email

Family/Surname

Date of Birth | D | M | Y |

Postcode

Mobile Phone

Section 2 — Travel Details

Is this trip for holiday/business?

Will you be backpacking? | Y | N |

Will you partake in adventure activities? | Y | N |

Will you be SCUBA diving? | Y | N |

Departure Date

Return Date

Will you be visiting rural or remote areas – please specify | Y | N |

Will you be visiting altitude areas? | Y | N |

I will be visiting the following countries

Country (in order of visit)	Cities	Duration (length of stay)

Please list countries you have visited previously

Section 3 — Health Details

Is your general health good? | Y | N |

Have you ever fainted or felt unwell soon after an injection? | Y | N |

Please list allergies

(Females) Are you pregnant or planning pregnancy? | Y | N |

Are you allergic to eggs, medications or other substances? | Y | N |

Please list ALL medications you are currently taking

Please list past significant medical/health problems you have had here and/or overseas. Especially note past history of jaundice, hepatitis, deep vein thrombosis (DVT) or blood clots, ear or hearing problems or a disease which lowers immunity (e.g. cancer, HIV/AIDS, Thymus disorder)

Vaccination History

Vaccine Given	Year	Vaccine Given	Year	Vaccine Given	Year
Tetanus/ Diphtheria/ Whooping Cough (pertussis)		Typhoid		Mantoux/BCG	
Polio		Cholera		Meningococcal	
Flu Vaccine		Hepatitis B		Japanese Encephalitis	
Pneumovax		Hepatitis A Vaccine		Q fever	
Measles / Mumps/ Rubella		Hepatitis A immunoglobulin		Yellow Fever	
Varicella (chicken pox)				Rabies	

Section 4 — Vaccine Information *(This section to be completed by Doctor)*

Travel risk assessment performed | Y | N |

Travel Vaccines to be given		
Vaccine	To be given	Given
ADT/Boostrix/IPV		
Polio (Sabin/IpO)		
Hib/Comvax		
Priorix		
Cholera oral (Dukoral)		
Flu Vaccine		
Fluvax/Fluarix/Vaxigrip/Jnr		
Hepatitis A		
Avaxim/VAQTA/Havrix/Jnr)		
Hepatitis B		

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Section 4 — Continued

Vaccine	To be given	Given
HBVax/Engerix)		
Twinrix / Jnr		
Mantoux / BCG		
Meningitis Menomune/		
Mencevax Neisvac C/ Meningitex/Menjugate		
Pneumococcal		
Rabies IM / ID		
MIRV/Verorab/Rabipur		
Typhoid		
Typhim VI/ Typherix/ Vivotif Oral 3 or 4/ Vivaxim		
Yellow Fever Stamaril		
Other		
Malaria Tablets		

Notes

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Dr's Signature (Dr's signature certifies discussion of risks and benefits of vaccines and medications with patient)

Signed _____ Date | D | M | Y |

Checklist

Yellow fever certificate stamped | | Pocket guide entered | |

Report given | | Recalls Entered | |