Sand-E Admin Pty Ltd as

BLUFF ROAD MEDICAL

328 Bluff Road Sandringham Vic 3191

Phone 9598 6244 Fax 95210514

As Association of Independent Medical Practitioners

Servicing Sandringham's Healthcare needs since 1987

A.B.N. 18 671 425 068

Health Questionnaire for International Travel

The detailed information enables us to individualise and tailor travel advice to your specific itinerary

Personal Details First Name: ________________________ Last Name: _____________________ DOB: ___________

Dates of your Trip Date of Departure: ____________ Return Date: ____________

Detailed Itineraries

Country	**Cities/Areas**	**Length of stay in days**	Altitude Y/N – Metres

Please mark all that describes your trip

Trip Type	Business	Holiday	Visiting Family / Other
Holiday Type	Package	Backpacking	Cruise / Trekking
Accommodation	Hotel (A/C)	Budget / Hostel	Camping / Relatives
Travelling	Alone	With Family / Partner	Friend / Group
Staying In	Urban Area	Rural Area	Mountain / Arid Region
Activities	Trekking	Safari / Adventure	Scuba / Extreme Activity

Health Status – Current & Past

Do you have OR have you had any of these medical problems (please indicate)

Asthma / Lung disease / Epilepsy / Diabetes / High Blood Pressure / Irregular Heart Beat /

Stomach Ulcer / Psoriasis / Blood Disorders / DVT / Weakened Immune system / HIV /

Mastectomy / Mood or Anxiety Issues / Splenectomy / Liver or Kidney disease / Thymus /

a) Any other medical problems (please specify)____

b) List any current or repeat medications you are taking now (eg contraceptive pills, antibiotics) ______________________

c) Are you allergic to (please circle) Eggs, Bees, Sulphur drugs, Penicillin, Latex, Band-Aids, Other ___________________

d) Have you ever felt faint or fainted after an injection or giving blood? Yes No

e) Could you be pregnant now OR any plans for pregnancy within 3 months of return Yes No

f) Does anyone around you have a weakened immune system? (Eg Cancer/HIV patients) Yes No

h) Have you ever had a serious reaction to previous vaccines? Yes No

i) Did you miss any of your usual childhood vaccinations? Yes No

VACCINATION HISTORY

Ns	**DISEASE**	**Previous Vaccination**	**Date**	**Brand/ Booster**	**X**	Dr's Schedule - *Recall done Y/N*
	Typhoid (IM / O)					
	Hepatitis A					
	Hepatitis B					
	Rabies					
	Tetanus/Pertussis					
	Polio					
	Flu					
	Meningitis ACWY / B					
	Yellow Fever(I)					
	MMR (I)					
	Chicken Pox(I)					
	Shingles VZV(I)					
	TB (I)					
	Hib					
	Japanese Encephalitis					
	Pneumonia 13 / 23					
	Cholera (o)					