Pre -Travel Appt Checklist

Please return the following forms to the Surgery as soon as they are completed (one per traveller)
Email: admin@rrmc.nz

Personal Details

Name: DOB:

Age at departure: Gender:

Email: Phone:

Recent Medical History

Please record the date and nature of any recent illnesses, operations, accidents or hospitalisations

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Past/Ongoing Medical History

□ Fear of flying
□ Anxiety/depression
□ Clotting disorders
□ Thrombosis/emboli (DVT/PE)
□ Respiratory disease/asthma
□ Immunosuppression
□ Heart disease/arrhythmia
□ Cancer treatment
□ G6PD Deficiency
□ Serious illness/other concerns (Please list)

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Are you currently pregnant or planning a pregnancy? □ Yes □ No

Plan to breast feed during the trip? □ Yes □ No

Are you on contraception? □ No □ Yes Name of Medication: ______________________

Medications

Please list all current medications including those taken daily and those taken as required.

Medication	Dose and frequency	Reason

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Travel Details:
Itinerary: ☐ Fixed ☐ Flexible

Date of departure from NZ: Date of return to NZ:

Have you been advised of any special requirements for the trip?

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Destination, Accommodation and Activity Details:
Please provide a brief outline of intended trip. Make sure to include any important features such as missionary work, work or visits with animals, adventure activities, travel at altitude etc. It is helpful for us to know the type of accommodation you plan to stay in too e.g. camping, hotels, hostels....

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Vaccination History:

Are you up to date with your NZ childhood immunisations? ☐ Yes ☐ No ☐ Unsure

Please indicate below any vaccinations you have previously received.

Vaccine	Approximate date received	Where vaccine was provided	FOR OFFICE USE ONLY
Cholera			
Hepatitis A			
Hepatitis B			
Influenza			
Japanese Encephalitis			
Meningococcal – (Menactra, Nimenrix, Bexsero)			
MMR (Measles, Mumps Rubella)			
Polio			
Tetanus, Whooping Cough Diphtheria			
Pneumococcal			
Rabies			
Shingles or Chickenpox			
Typhoid			
Combined Hep A/B			
Other			

History of Allergies
Do you have an allergy to egg? ☐ Yes ☐ No. Vaccine allergy? ☐ Yes ☐ No.

Do you have any other allergies (include medications, over the counter remedies and foods please)?

☐ No ☐ Yes. If yes, list____

Have you ever taken anti-malarial medications? ☐ No ☐ Yes. If yes, please provide details of which medications, when and any side effects: ____

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Office use only:

- ☐ Travel documentation completed
- ☐ Post vaccine information provided
- ☐ F/up appt booked if needed
- ☐ Recalls set
- ☐ Worldwise country info provided