

Matamata Medical Centre Pre-Travel Questionnaire / Consultation



Please complete the following for each individual traveller

Personal Information:

NAME: _____ Date of Birth: ___/___/_____

Contact Details; Home ph: _____ Mobile: _____ Email: _____

Usual Doctor / Medical Centre: _____

Medical History:

Please indicate if any of the following apply	Yes	No		Yes	No
Heart Disease			High Blood pressure		
Diabetes			Cancer		
If yes: On Insulin			Epilepsy		
On oral medication			Smoker		
Asthma or other Lung disease			List any other medical Conditions:		
Pregnant					
If yes; expected date of delivery:					
Post Natal- Breast feeding					
Any recent surgery? Type.....					

Medications: _____

Any Known Allergies: _____

Vaccinations:

Have all childhood vaccinations been given? Yes / No

Dates if known for last; Tetanus Polio Influenza

MMR(Measles/Mumps/Rubella) Pertussis (Whooping cough)

Please circle if you have received any of the following travel vaccinations:

Hepatitis A Hepatitis B Typhoid Yellow Fever Rabies Meningitis

Tuberculosis Japanese Encephalitis

Intended Travel destinations:

When are you intending to travel? _____ Expected time away? _____

Have you been to this destination/s before? _____

Intended purpose for travel: (Please circle all that apply) Business Conference Sport Education Holiday

Resort / Organised tour / Visiting family or friends / No fixed itinerary

Adventure tourism – Camping / Tramping Special Activities Seeking health care (Medical Tourism)

Please list travel destinations, accommodation type & expected time spent at each destination

The above information is accurate to the best of my knowledge.

Signed: _____

Thankyou for completing the questionnaire. The information will be discussed during your consultation.



Matamata Medical Centre

Name: _____

NHI: _____

DOB: _____

Matamata Medical Centre Travel Vaccination Schedule / Record

Recommended Vaccine	Dosage & Route	Date Given Day 0	Day 7	Day 14	Day 21	Day 28	Booster doses due
Diphtheria Tetanus (ADT) <input type="checkbox"/>	IM (>10yrs since last dose)	*					
Polio <input type="checkbox"/>	S/C Single booster	*					
Measles Mumps Rubella (MMR) <input type="checkbox"/>	Live attenuated vaccine S/C	*				*(if no childhood vaccination)	
Varicella <input type="checkbox"/>	Live attenuated vaccine S/C from age 9-12mths	*					
Influenza <input type="checkbox"/>	IM / S/C	*					Annual
HepatitisA <input type="checkbox"/>	IM	*					1-5yrs
HepatitisB <input type="checkbox"/>	IM (Accelerated dosing)	*	*			*	6 months a/a
Typhoid <input type="checkbox"/>	IM For >2yrs age Oral Live attenuated vaccine for >6yrs	*	*	*			*3yrs if repeated exposure risk

Recommended Vaccine	Dosage & Route	Date Given Day 0	Day 7	Day 14	Day 21	Day 28	Booster doses due
Japanese Encephalitis <input type="checkbox"/>	IM 2 doses 18yrs+	*				*	
Cholera (@ least 1wk prior to exposure) <input type="checkbox"/>	Oral. >6yrs 2 doses. 2-6yrs 3 doses	*	*	*			2yrs *6mths
Rabies <input type="checkbox"/>	IM (3 doses)	*	*		*	Or *	
Yellow Fever <input type="checkbox"/>	Live attenuated vaccine S/C From 9 mths age.	*					
Meningitis (Menactra ACYW) <input type="checkbox"/>	IM 2 -55yrs 9-23mths 2 doses, day 0 & 3mths	*					5yrs if at risk area
Meningitis (Bexsero - Group B) <input type="checkbox"/>	IM From 11yrs 2 doses 1-10yrs 2 doses 2-11mths 3 doses	*	*			*	*2mths & booster after 1yr of age

Combination Vaccines Available:

HepA/Typhoid (Vivaxim) Administer single dose. HepA booster 1-5yrs

HepA/HepB (Twinrix) Administer as per HepB schedule

Diphtheria/Tetanus/Polio/Pertusis (Boostrix-IPV or Adacel Polio) Administer single dose