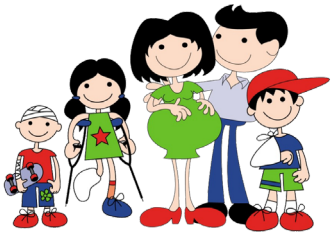

Coastal Family Health

Pre- travel consultation form

Patient Name:_____ Date of Birth:___/____/____

Please bring this form completed to your appointments, along with any other vaccine history you have.

Please circle Yes or No

Appointment Date: / /	Dr:
Are you a current patient of Currimundi Family Doctors?	Yes No
If not, would you like us to notify your GP of your vaccinations?	Yes No Practice:

Travel Information

Departure Date: / /	Return Date: Date: / /	
Countries you are visiting	Duration of stay	Rural areas? Yes No Yes No Yes No Yes No
Are you in general good health?	Yes No	
Are you needle phobic, have you ever fainted or been unwell after an injection?	Yes No	
Are you pregnant or planning a pregnancy?	Yes No	
Do you live with anyone with a low immunity?	Yes No	
Other people travelling:	Do they also require vaccinations? Yes No Yes No Yes No Yes No	
Do you have any allergies to medication, eggs or other foods? Please list all allergies:	Are you receiving medications that lower your immunity (e.g. oral steroids, chemotherapy)? If yes, please list:	
Have you had a past history of Guillain- Barre Syndrome?	Yes No	
Please list any diseases or conditions you have or have had when travelling (e.g. HIV, Deep vein thrombosis(DVT), Hepatitis, hearing or ear problems, etc):		

Patient Signature: _____ Date: _____/_____/_____