TRAVEL DOCTOR

HEAD OFFICE
NHC Health Centre, Cnr Beyers Naude & Waugh, Northcliff
P.O. Box 2938, Cresta 2118, South Africa
Tel:+27 (11) 214 9030 • Fax:+27 (11) 214-9029
Website: www.traveldoctor.co.za
E-mail: info@traveldoctor.co.za

PRE-TRAVEL QUESTIONNAIRE

Please use block letters, provide complete answers and tick ☑ where applicable.

YOU - A

Surname: _____ First Names: _____

Country of Birth: _____ Gender: Male ☐ Female ☐

Date of Birth: DD / MM / YYYY Age: _____ Tel (Home): _____

Postal Address: _____ Tel (Work/Cell): _____

_____ Fax: _____

Postal Code: _____ E-Mail: _____

Employer: _____ Occupation: _____

Department/Cost Centre: _____ Employer No: _____

YOUR HEALTH - B

1. Have you travelled to developing countries before? YES ☐ NO ☐
2. Did you have any health problems while away? YES ☐ NO ☐
3. Do you have any medical problems? e.g. Asthma, Diabetes; Thymus Disease; Psoriasis; Stomach Ulcer; Splenectomy; Epilepsy; Depression; Anxiety Attacks; High Blood Pressure; Blood Clotting Disorders; Irregular Heart Beat; HIV/Aids; Cancer YES ☐ NO ☐
   If yes, please specify _____
4. Have you been hospitalised in the last six weeks? YES ☐ NO ☐
5. List major surgery undergone e.g. Cardiothoracic; Thymectomy
6. Have you had Hepatitis A (Yellow Jaundice)? YES ☐ NO ☐
7. Are you currently on any medication (e.g. contraceptive pill; steroids; antibiotics; migraine tablets; asthma inhaler)? YES ☐ NO ☐
   List all medications (chronic & occasional): _____
8. Are you allergic to anything (e.g. sulpha drugs; penicillin; iodine; eggs; bee stings; latex; band aids)? YES ☐ NO ☐
   If yes, please specify _____
9. Have you ever felt faint or fainted after having an injection? YES ☐ NO ☐
10. Do you weigh less than 45kg? YES ☐ NO ☐
11. Did you miss any of your usual childhood vaccines? YES ☐ NO ☐
12. Do you have any particular health concerns regarding this trip? YES ☐ NO ☐
    If yes, please outline _____
13. **Women:** Could you be pregnant now, or do you plan to become pregnant within the next 3 months? YES ☐ NO ☐

Signature: _____ Date: _____

I declare and warrant that the personal health information above is complete and true. I acknowledge that I remain personally responsible for this account in the event of non-payment by my employer.

YOUR TRIP - C

1. Purpose of your trip? ☐ Holiday ☐ Visiting Family/Friend ☐ Business ☐ Other
2. Type of accommodation? ☐ Camping ☐ Budget ☐ Air conditioned hotel ☐ Private home
   ☐ Other _____
3. Will you be undertaking any adventure activities? ☐ Scuba Diving ☐ Mountain Climbing ☐ Piloting an Aircraft
   ☐ Other (please specify) _____
4. Please list the countries you intend visiting, and how long (in weeks) you plan to spend in each.
   4.1. Country: _____ Departure Date: _____ Return Date: _____ Weeks: _____
   4.2. Country: _____ Departure Date: _____ Return Date: _____ Weeks: _____
   4.3. Country: _____ Departure Date: _____ Return Date: _____ Weeks: _____

OTHER - D

1. How did you learn of this Travel Doctor? _____

☐ Been to this Travel Clinic before?

☐ Been to another Travel Clinic? Where: _____

☐ Travel Agent

☐ My Doctor Name of your General Practitioner: _____

2. How will you be paying for your visit?

☐ Cash ☐ Credit Card ☐ Company ☐ Order Number _____

FOR INTERNAL USE

VACCINATIONS - E

☐ BCG _____
☐ Cholera _____
☐ Hepatitis A _____
☐ Hepatitis B _____
☐ Japanese Encephalitis _____
☐ Meningococcus ACWY _____
☐ Polio (OPV/IPV) _____
☐ Rabies _____
☐ Tetanus Boost _____
☐ Typoid (oral/injection) _____
☐ Other _____

☐ Varicella _____
☐ DPT+Hib+HepB _____
☐ Hepatitis A+B _____
☐ Influenza _____
☐ Meningococcus A+C _____
☐ MMR _____
☐ Pneumococcus _____
☐ Rubella _____
☐ Td Polio _____
☐ Yellow Fever _____

Consultation conducted by: _____

Date: _____

PRESCRIPTION - F

☐ Mefloquine _____
☐ Malanil® _____
☐ Coartem® _____

☐ Doxycycline _____
☐ Fansidar® _____
☐ Acetazolamide _____

OTHER PRODUCTS - G

☐ Medical Kit (car)
☐ Rapid Test Kit (5)
☐ Insect Rep (Lotion)
☐ Citronella Soap

☐ Medical Kit (gastro)
☐ Insect Rep (Stick)
☐ Mosquito Net
☐ Water Purification

☐ Medical Kit (Personal)
☐ Insect Rep (Spray)
☐ Net Treatment Pack