

# Health Service - Clayton Campus

## Travel Questionnaire

Name: \_\_\_\_\_  
\_\_\_\_\_

D.O.B: \_\_\_/\_\_\_/\_\_\_\_ (dd/mm/yyyy)

Date: \_\_\_/\_\_\_/\_\_\_\_ (dd/mm/yyyy)

1. Date of departure: \_\_\_/\_\_\_/\_\_\_\_ (dd/mm/yyyy)

Date of return: \_\_\_/\_\_\_/\_\_\_\_ (dd/mm/yyyy)

2. Complete your travel itinerary, preferably in chronological order.

Country	Region Urban/Rural	Length of Stay	Month of Year	Type of Travel (eg. bus, backpack)	Type of Accommodation

3. In which country(s) did you spend your childhood? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you complete your routine  
4. childhood immunisation? (please circle) Yes No Uncertain

5. Have you suffered or been vaccinated against any of the following diseases?

	<b>Disease Yes/No</b>	<b>Year of last vacc</b>		<b>Disease Yes/No</b>	<b>Year of last vacc</b>
Tetanus*			Typhoid		
Diphtheria*			Hepatitis A		
Polio			Hepatitis B		
Measles**			Meningococcal Meningitis		
Mumps**			Japanese Encephalitis		
Rubella** (German Measles)			Rabies		
Hib (Haemophilus Influenza B)			Pneumococcal Pneumonia		
Tuberculosis (BCG vaccine)			Influenza Virus		
Yellow Fever			Other		

\* In Australia the final routine diphtheria and tetanus is given in Year 9

\*\* MMR routinely given at age 12 months since 1989 \*\* MMR routine given in Year 6 since 1994

**Have you ever experienced an adverse  
6. reaction to the above vaccine?** (please circle) Yes No

**Which vaccine?**

**Describe the reaction**

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**7. Are you allergic to any drugs or  
medications?** (please circle) Yes No

**If yes, describe**

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**8. Are you allergic to eggs or do you  
suffer from any other allergies?**  
(please circle) Yes No

**If yes, describe**

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\_\_\_\_\_

9. **Do you have a deficiency of the immune system?** (please circle) Yes No

10. **Are you a blood donor?** (please circle) Yes No  
If yes, last date donated? \_\_\_/\_\_\_/\_\_\_\_\_ (dd/mm/yyyy)

11. **Do you have any past or existing medical conditions, in particular of the heart, lungs, diabetes, epilepsy or skin diseases?** (please circle) Yes No

**Details**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. **Have you had any operations?** (please circle) Yes No

**Details**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. **Are you currently suffering from any particular illness?** (please circle) Yes No

**Details**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. **Have you been diagnosed with any mental health illness?** (please circle) Yes No

15. **Please list all current medications (including contraception)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. **Are you pregnant, trying to become pregnant or breastfeeding?** (please circle) Yes No

17. **Is there a personal or family history of "thrombosis", "DVT" or blood clots?** (please circle) Yes No

18. Have you previously taken any anti-malarials? (please circle) Yes No

Which?

\_\_\_\_\_

\_\_\_\_\_

If Yes, for how long?

\_\_\_\_\_

\_\_\_\_\_

Any adverse reactions? (please circle) Yes No

If yes, please describe

### Physician's comments

Presumptive Malaria Treatment	
	Duration or Quantity
Fansidar tablets Take 3 as a single dose	
Mefloquine 250mg base tablets Take 2 immediately then 2, 6-8 hours later	

Malaria Prophylaxis	
	Duration or Quantity
Chloroquine 150mg base tablets 2 tablets once each week	
Mefloquine 250mg base tablet 1 tablet each week	
Doxycycline 100mg tablets 1 tablet daily	

### Other Medications

Bowel Kit	Quantity
Loperamide 2mg	

<b>Norfloxacin 400mg</b>	
<b>Tinidazole 500mg</b>	
<b>Electrolyte replacement solution</b>	
<b>Prochlorperazine maleate</b>	

## **Additional Medication**

<b>Drug name &amp; form</b>	<b>Strength</b>	<b>Dose</b>	<b>Route &amp; frequency</b>	<b>Quantity</b>