pre-travel assessment form

pvh medical

PERSONAL DETAILS

Today's Date: ____________________

Mr ☐ **Miss** ☐ **Ms** ☐ **Mrs** ☐ **Dr** ☐

Surname: ________________________ **Given Name:** _____________________

Gender: Male ☐ Female ☐

Date of Birth: ________/____________/____________

Home Address:

(Street Number) ____________ (Street Name) _________________________________

(Suburb) __________________ (State) _____________ (Postcode) ________________

HEALTH CARE CARDS

MEDICARE

Card Number: _____________________ Reference Number (next to your name): _____

Expiry Date: ______________________

PRIVATE HEALTH INSURANCE

Health Fund: ______________________ Membership Number: ____________________

Level of Cover: ____________________

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YOUR REGULAR GP

Are you a patient of PVH Medical? Yes ☐ No ☐

IF YES:
Who is your regular GP? ___________________________

IF NO:
Name & address of your regular medical practice and GP

Medical Practice: _________________________________

Name of Regular GP: ______________________________

Medical Practice Address:

(Street Number) _____________ (Street Name) ___________________________________

(Suburb) ____________________ (State) ______________ (Postcode) _________________

Would you like us to notify your regular GP of vaccinations given? Yes ☐ No ☐

YOUR TRIP ITINERARY

Date of Departure: __________/_____________/_____________

Date of Return: _____________/_____________/_____________

Country Visiting (in order)	City / Town / Region visiting in that country	Duration of stay (in days)	Accommodation Type				
			Hotel	Hostel	Relatives / Friends	Camping	Other

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Are you travelling:-

alone ☐
with partner and/or family ☐
in a tour group ☐
with friends ☐

Names of other family members travelling with the same itinerary, who are also attending PVH Medical's travel health clinic:

____

____

____

____

Please list countries you have visited previously:

____

____

____

____

YOUR HEALTH

	Yes	No
Is your general health good?		
Does someone with lowered immunity live at home with you?		
Have you ever fainted or felt unwell soon after an injection?		
Have you ever had a severe reaction to a vaccine previously?		
Could you be, or are you planning to be pregnant while you are away, or within 3 months of your return?		
Are you allergic to EGGS, MEDICATIONS or other substances? (if Yes, give details)		

Do you, or have you had, any of the following:	**Yes**	**No**
Asthma		
Diabetes		
Epilepsy		
Heart disease		
High blood pressure		
Irregular heart beat		
HIV / AIDS		
Leukaemia		
Blood clotting disorder		
DVT or pulmonary embolus		
Previous transplant		
Cancer		
Recent chemotherapy or radiotherapy		
Myasthenia Gravis		
Weakness of the immune system		
Hepatitis or jaundice		
Any other medical problems / condition? (if Yes, give details)		
Are you currently taking any medication? (if Yes, give details)		

VACCINATION HISTORY

In order to avoid unnecessary vaccinations, you need to complete the following table **BEFORE** your appointment. Please put the approximate year you have any of the following vaccines or diseases, You can check with your usual GP or previous records to find this information, if necessary.

Have you had any of the following vaccinations?	**Yes**	**No**	**If Yes, what year**
Tetanus / diphtheria / whooping cough			
Tetanus			
Tetanus / whooping cough (Boostrix)			
Influenza vaccine			
Swine flu (H1N1) vaccine			
Varicella (chicken pox)			
Measles / mumps/ rubella (MMR)			
Typhoid			
Polio			
Cholera			
Hepatitis A			
Hepatitis B			
Gardasil (HPV)			
Pneumovax			
Meningococcal B			
Meningococcal C			
Japanese encephalitis			
Q fever			
Rabies			
Yellow fever			
Mantoux or BCG			

CONSENT AND PRIVACY

Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times in accordance with privacy laws, and to ensure that this information is only available to authorised people. More information about how the practice handles your record is available to you upon request.

Our practice undertakes research, professional development and quality assurance improvement activities to improve patient care. We use a reminder system to improve the quality of your health care, and send out reminders for procedures such as vaccinations, Pap tests and other health reviews.

The doctors at our practice have been appointed as clinical teachers by the University of Melbourne. Please advise your doctor if you have concerns about having a student involved in your consultation, or do not wish to receive reminders in the post.

TRANSFER OF HEALTH INFORMATION

You may have a health record at another practice. If you wish to have a copy or summary of your health records transferred to this practice, please ask reception.

I acknowledge that the information provided on this registration form is true and accurate.

Signature of patient (or parent/guardian): ______________________________ Date: __________________

Print Name : ____