TRAVELLER CHECKLIST (one to be filled out for each traveller)

Family Name _____

Address _____

_____

Email _____

Given Name _____

Date of Birth _____

Phone Number _____

Occupation _____

Departure Date _____

Total length of trip _____

Destinations List all (provide as much detail as possible)

Country Length time (days/mths)

_____

_____

_____

_____

_____

_____

Transport type (tick all that apply)

Air ☐ Train ☐

Sea/river ☐ Road ☐

Other _____

_____

Accommodation (tick all that apply)

Hotels ☐ Hostels ☐

Camping ☐ Visiting friends/family ☐

Other _____

Activities

Skiing ☐ Bushwalking/hiking ☐

Cycling ☐ Water sports (kayak, swimming, diving) ☐

Motorcycling ☐ Climbing/altitude ☐

Other _____

_____

Type of Trip

Holiday ☐ Individual ☐

Business ☐ Group tour ☐

Visiting friends/family ☐

Other _____

Where?

Rural ☐ Urban ☐

Previous travel history (and any problems/experiences)

_____

_____

_____

_____

Allergies (including anaphylaxis to meds, egg, previous vaccines)

_____

_____

_____

Previous vaccinations (and any problems/experiences)

Date last vaccine and any adverse event

Tetanus ☐ _____

Diphtheria ☐ _____

Pertussis (whooping cough) ☐ _____

Measles ☐ _____

Mumps ☐ _____

Rubella ☐ _____

Polio ☐ _____

BCG (Tuberculosis) ☐ _____

HIB (Haemophilus) ☐ _____

Pneumococcal ☐ _____

Varicella (ch. pox) ☐ _____

Any vaccine in last month? ☐ Yes ☐ No

Date last vaccine and any adverse event

Meningococcal ☐ _____

Hepatitis A ☐ _____

Hepatitis B ☐ _____

Typhoid ☐ _____

Cholera ☐ _____

Yellow Fever ☐ _____

Influenza ☐ _____

Rabies ☐ _____

Jap Encephalitis ☐ _____

Zoster (shingles) ☐ _____

COVID19 (No. inj) ☐ _____

Date last vaccine and any adverse event

Other ☐ _____

Other ☐ _____

Date last vaccine and any adverse event

Other ☐ _____

Other ☐ _____

Medical history (tick all that apply)

Respiratory/Lung

- Asthma ☐
- COAD ☐
- Emphysema ☐
- Pulm Embolism ☐
- Tuberculosis ☐
- Other (list) ☐

_____

Cardiac/Heart

- High Blood Pressure ☐
- Angina/Heart Attack ☐
- Heart Murmur ☐
- Rheumatic Fever ☐
- Rhythm problem ☐
- Other heart problem ☐

_____

Neurological/Brain

- Stroke ☐
- TIA ☐
- Epilepsy/convulsion ☐
- Guillain Barre ☐
- Other ☐

_____

Haematological/Blood

- Leukaemia ☐
- Lymphoma ☐
- Anaemia ☐
- DVT/leg clot ☐
- Thymus op ☐
- Other (list) ☐

_____

Mental Health

- Depression ☐
- Anxiety ☐
- Schizophrenia ☐
- Bipolar ☐
- Other (list) ☐

_____

Gastrointestinal

- Peptic ulcer ☐
- Crohn's ☐
- Colitis ☐
- Liver disease ☐
- Hepatitis ☐
- Splenectomy ☐

Blood transfusion or **immunoglobulin** past 12 months? ☐ Yes ☐ No

Stem cell therapy ☐ Yes ☐ No

Kidney Disease (list) ☐

_____ ☐

HIV ☐

Any cancer (list including date)

_____

_____

Recent chemo/radiotherapy ☐

Obesity ☐

Psoriasis ☐

On blood thinners ☐
(list under medications below)

Autoimmune Disease ☐

List _____

Altitude illness previously ☐

Endocrine

- Diabetes ☐
- Thyroid problem ☐
- Transplant history ☐

_____

_____

History of immunosuppression ☐ Yes ☐ No Give details _____

Previous Surgery (list all operations)

_____

_____

_____

_____

_____

Last Dental Visit _____

Pregnant/planning preg ☐ Yes ☐ No

Breastfeeding ☐ Yes ☐ No

Medications (include **all** prescribed, over the counter, vitamins, herbal, regular and rare etc)

Name	Dose	Frequency	Name	Dose	Frequency

Are you well today? ☐ Yes ☐ No

Other Information: _____

Signature _____ **Date** _____