

PATIENT TRAVEL INFORMATION					
Family Name:		First Name:			
Address:		Date of Birth:		Male / Female	
Are you a NZ citizen Resident		NHI number (if known)			
Email address:					
Contact Phone number:		Work:			
Home:		Mobile:			
Occupation:		Company name (if work related travel):			
General Practitioner:					
Next of kin (name, relationship, phone number)					
YOUR HEALTH. (If you usually see a doctor at Te Ngae Medical Centre you do not need to complete this section)					
List any Vaccinations / Immunisations you have had in the last 10 years.					
Did you have the usual childhood vaccinations?					
Please describe any reactions to vaccinations.					
Please list any allergies. Any to food, Eggs or medicines .					
Do you react to bee stings ?					
What present / past medical conditions do you / did you have ?					
Please list any medications you are currently taking or have taken in the last 2 months.					
Do you presently have a temperature or flu /cold symptoms ?					
Females only – Are you Pregnant / contemplating pregnancy ?					
Do you have a history of the following ?					
Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Convulsion/Seizure/Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart rhythm problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric unwellness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood immune disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood clotting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How did you find out about Te Ngae Medical Centre’s Travel Advice service?					
COUNTRIES TRAVELLING TO:			DURATION:		
DEPARTURE DATE:			RETURN DATE:		

INFORMED CONSENT

I acknowledge that to the best of my knowledge the information I have provided is correct. The information will be kept confidential to your medical team at Te Ngae Medical Centre.

I understand I may be given vaccinations, understand what they are for, and that some vaccinations may cause side effects.

I consent to having these vaccinations and to pay the appropriate fee for them and the administration of said vaccines.

PATIENT – self / parent / caregiver:

SIGNATURE:

DATE: