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	☐ Yes	☐ No	Convulsion/Seizure/Epilepsy	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Heart rhythm problems	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Psychiatric unwellness	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Blood immune disorders	☐ Yes	☐ No
Blood clotting	☐ Yes	☐ No	Recent surgery	☐ Yes	☐ 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: