HEAD OFFICE
NHC Health Centre, Cnr Beyers Naude & Waugh, Northcliff
P.O. Box 2938, Cresta 2118, South Africa
Tel:+27 (11) 214 9030 • Fax:+27 (11) 214-9029
Website: www.traveldoctor.co.za
E-mail: info@traveldoctor.co.za

PRE-TRAVEL QUESTIONNAIRE

Please use block letters, provide complete answers and tick ☑ where applicable.

YOU - A

Surname: ______________________________

Country of Birth: ______________________________

Date of Birth: DD / MM / YYYY Age: __________

Postal Address: ______________________________

____

Postal Code: ______________________________

Employer: ______________________________

Department/Cost Centre: ______________________________

First Names: ______________________________

Gender: Male ☐ Female ☐

Tel (Home): ______________________________

Tel (Work/Cell): ______________________________

Fax: ______________________________

E-Mail: ______________________________

Occupation: ______________________________

Employer No: ______________________________

YOUR HEALTH - B

1. Have you travelled to developing countries before? YES ☐ NO ☐
2. Did you have any health problems while away? YES ☐ NO ☐
3. Do you have any medical problems? e.g. Asthma, Diabetes; Thymus Disease; Psoriasis; Stomach Ulcer; Splenectomy; Epilepsy; Depression; Anxiety Attacks; High Blood Pressure; Blood Clotting Disorders; Irregular Heart Beat; HIV/Aids; Cancer YES ☐ NO ☐
   If yes, please specify ______________________________
4. Have you been hospitalised in the last six weeks? YES ☐ NO ☐
5. List major surgery undergone e.g. Cardiothoracic; Thymectomy
6. Have you had Hepatitis A (Yellow Jaundice)? YES ☐ NO ☐
7. Are you currently on any medication (e.g. contraceptive pill; steroids; antibiotics; migraine tablets; asthma inhaler)? YES ☐ NO ☐
   List all medications (chronic & occasional): ______________________________
8. Are you allergic to anything (e.g. sulpha drugs; penicillin; iodine; eggs; bee stings; latex; band aids)? YES ☐ NO ☐
   If yes, please specify ______________________________
9. Have you ever felt faint or fainted after having an injection? YES ☐ NO ☐
10. Do you weigh less than 45kg? YES ☐ NO ☐
11. Did you miss any of your usual childhood vaccines? YES ☐ NO ☐
12. Do you have any particular health concerns regarding this trip? YES ☐ NO ☐
    If yes, please outline ______________________________
13. **Women:** Could you be pregnant now, or do you plan to become pregnant within the next 3 months? YES ☐ NO ☐

Signature: ______________________________ Date: ______________________________

I declare and warrant that the personal health information above is complete and true. I acknowledge that I remain personally responsible for this account in the event of non-payment by my employer.

YOUR TRIP - C

1. Purpose of your trip? ☐ Holiday ☐ Visiting Family/Friend ☐ Business ☐ Other
2. Type of accommodation? ☐ Camping ☐ Budget ☐ Air conditioned hotel ☐ Private home ☐ Other ______________________________
3. Will you be undertaking any adventure activities? ☐ Scuba Diving ☐ Mountain Climbing ☐ Piloting an Aircraft ☐ Other (please specify) ______________________________
4. Please list the countries you intend visiting, and how long (in weeks) you plan to spend in each.
   4.1. Country: __________ Departure Date: __________ Return Date: __________ Weeks: __________
   4.2. Country: __________ Departure Date: __________ Return Date: __________ Weeks: __________
   4.3. Country: __________ Departure Date: __________ Return Date: __________ Weeks: __________

© Travel Doctor

OTHER - D

1. How did you learn of this Travel Doctor? ______

- [ ] Been to this Travel Clinic before?
- [ ] Been to another Travel Clinic? Where: ______
- [ ] Travel Agent
- [ ] My Doctor Name of your General Practitioner: ______

2. How will you be paying for your visit?

- [ ] Cash
- [ ] Credit Card
- [ ] Company
- [ ] Order Number ______

VACCINATIONS - E

- [ ] BCG ______
- [ ] Cholera ______
- [ ] Hepatitis A ______
- [ ] Hepatitis B ______
- [ ] Japanese Encephalitis ______
- [ ] Meningococcus ACWY ______
- [ ] Polio (OPV/IPV) ______
- [ ] Rabies ______
- [ ] Tetanus Boost ______
- [ ] Typoid (oral/injection) ______
- [ ] Other ______
- [ ] Varicella ______
- [ ] DPT+Hib+HepB ______
- [ ] Hepatitis A+B ______
- [ ] Influenza ______
- [ ] Meningococcus A+C ______
- [ ] MMR ______
- [ ] Pneumococcus ______
- [ ] Rubella ______
- [ ] Td Polio ______
- [ ] Yellow Fever ______

Consultation conducted by: ______

Date: ______

PRESCRIPTION - F

- [ ] Mefloquine ______
- [ ] Malanil® ______
- [ ] Coartem® ______
- [ ] Doxycycline ______
- [ ] Fansidar® ______
- [ ] Acetazolamide ______

OTHER PRODUCTS - G

- [ ] Medical Kit (car)
- [ ] Rapid Test Kit (5)
- [ ] Insect Rep (Lotion)
- [ ] Citronella Soap
- [ ] Medical Kit (gastro)
- [ ] Insect Rep (Stick)
- [ ] Mosquito Net
- [ ] Water Purification
- [ ] Medical Kit (Personal)
- [ ] Insect Rep (Spray)
- [ ] Net Treatment Pack

© Travel Doctor