Dunedin North Medical Centre

Travel Consultation

Title: (Circle one) Dr Mr Mrs Ms Miss Master

Family Name: _____

First Names: _____ **Known as:** _____

Date of Birth: _____ **NHI:** _____ **Country of Birth:** _____

Gender:

Male ☐	Female ☐	Gender diverse ☐ *Please state:*

Home Address *(Requires a street or rapid address number, not RD, PO Box or Private Bag)*

Street & Number: _____

Suburb: _____ **City:** _____ **Postcode:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Email address: _____

Next of Kin/Emergency Contact: Name: _____ **Relationship:** _____

Phone, mobile or other: _____

Ethnicity: *Which ethnic group do you belong to? Please tick the box or boxes that apply.*

☐ NZ European	☐ Cook Island Maori	☐ Chinese
☐ Maori	☐ Tongan	☐ Indian
☐ Samoan	☐ Niuean	☐ Other (please state)_____

Are you a: *Please tick the box that applies.*

☐ **New Zealand Resident** ☐ **Non resident**

Signature: _____ **Date:** _____

Please Note: *Patients under 16 years of age require a parent or caregiver's signature and additional details below.*

Parent or caregivers name: _____ **Relationship:** _____

Contact phone number *(if not provided above)*: _____

DNMC Travel Medical Questionnaire

Full Name			
Date of Birth		NHI (if known)	

Section A – Travel Details

All patients - please complete this questionnaire and bring to the travel consultation. Travellers who are enrolled patients at Dunedin North Medical Centre do not need to complete section B.

Please describe in as much detail as possible your itinerary for this trip

If you are travelling to Africa or South America you may be at risk of Yellow Fever exposure – please see our website Yellow Fever information and the affected countries on the CDC website: http://www.cdc.gov/yellowfever/maps/ - If you are travelling to these areas please ensure you let reception know to ensure you get the correct appointment for this.

What activities will you be doing on this trip *(working, backpacking, climbing, diving etc)*

Will you be at altitude? If yes, how high and how long? (please describe your trip and acclimatisation schedule.)

If yes have you been to altitude before – Please describe.

Did you have any problems or altitude related illness.

Previous vaccinations ***(please bring any records of past vaccination that are available)***

Date	Vaccine	Number of doses given

Last Tetanus booster

Did you have childhood vaccinations in New Zealand? ☐ Yes ☐ No
If elsewhere please list.

Do you have any questions?

Section B – Background Information

Intending travellers who are enrolled patients at Dunedin North Medical Centre do not need to complete this section.

Contact phone numbers	
Email	
Home Address	

Background Health

1. Do you have any ongoing health problems? ☐ Yes ☐ No
Please describe

2. Do you take any medications or supplements? ☐ Yes ☐ No
Include inhalers, creams and contraception if applicable
Please list names and doses

4. Have you ever had an operation or any significant illness requiring time in hospital?
☐ Yes ☐ No
Please list

5. Do you have any allergies or medications you cannot take? ☐ Yes ☐ No
Please list.
