

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 <input type="checkbox"/>	Female <input type="checkbox"/>	Gender diverse <input type="checkbox"/> <i>Please state:</i>
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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.

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> NZ European | <input type="checkbox"/> Cook Island Maori | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Maori | <input type="checkbox"/> Tongan | <input type="checkbox"/> Indian |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Niuean | <input type="checkbox"/> Other (please state) _____ |

Are you a: Please tick the box that applies.

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> New Zealand Resident | <input type="checkbox"/> 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

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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.
