



Thank you for contacting Ropata Medical Centre for your travel health needs.

It is important when planning travel to ensure you see your health professional at least four weeks prior to your departure (and in some situations you may require a longer time). However, if this is not possible we are usually able to be of some assistance when contacted at short notice.

When you contact us you will be asked to complete a pre-travel questionnaire.

It is important that you complete it as accurately as you can as this is where the Doctor collects the information to determine your travel medicine requirements. This is especially important when, for example, travelling to Yellow Fever endemic countries (some countries in South America and Africa) and also countries which have Malaria as often not all of a country has malaria-risk.

Once we have your fully completed questionnaire, we will contact you to make an appointment with a Doctor. Following your appointment with the Doctor, you will see the Nurse for any vaccinations required.

If you have not heard from us within one week please contact us.

Below is an outline of the cost of the service – payment will be required **prior** to each consultation.

- | | |
|---|-------|
| • Doctor Consult – Ropata patient | \$48 |
| • Doctor Consult – Casual patient | \$100 |
| • Any additional Nurse's consultations – Ropata patient | \$35 |
| • Any additional Nurse's consultations – Casual patient | \$65 |
| • Maximum fee for a family consultation | \$180 |
| • Vaccines are charged separately | |



Travelmed@**ROPATA** MEDICAL CENTRE
Caring for the Community

PRE-TRAVEL QUESTIONNAIRE

It is important to visit your Doctor or Travel Health professional well in advance of travelling overseas. Please fill in this questionnaire and return it as soon as possible. You can e-mail it: Travelmed@Ropata.net.nz fax it: 9200 873, or drop it into us at 577 High Street, Lower Hutt.

GENERAL INFORMATION

Full name (Surname first): _____

Address: _____

Date of Birth: ____/____/____ Age: ____

NOK details: _____

Male: ☐

Female: ☐

NZ Resident: Yes ☐ No ☐

Previously seen at Ropata Medical Centre: Yes ☐ No ☐

GP's name and address if not registered at Ropata: _____

PREFERRED METHOD OF CONTACT

E-mail ☐

Phone ☐

Fax ☐

E-mail address: _____

Phone (home): _____

Phone (work): _____

Mobile: _____

May we leave a message/information regarding your appointment? Yes ☐ No ☐

Home/mobile answer machine ☐

Voicemail at work ☐

E-mail ☐

TRAVEL INFORMATION

Purpose of travel:

- ☐ Holiday
- ☐ Business
- ☐ Missionary/voluntary work
- ☐ Adventure holiday e.g. backpacking overland
- ☐ Other, please specify: _____

If on an Adventure holiday or backpacking what are your proposed activities?

- ☐ Cycling
- ☐ Diving
- ☐ Climbing >3000m
- ☐ Safari
- ☐ Other, please specify: _____

TYPE OF TRAVEL

- ☐ Independent
- ☐ Group/tour
- ☐ Fixed Itinerary
- ☐ Flexible Itinerary
- ☐ Cruise ship
- ☐ Other, please specify: _____

DESTINATION(S) IN ORDER OF TRAVEL:

PLEASE ATTACH A COPY OF YOUR ITINERARY IF YOU HAVE ONE, OR EXTRA PAGE IF REQUIRED, FOR PLACES YOU ARE VISITING

****TOTAL NUMBER OF DAYS AWAY FROM NZ ()**

Country/Province/Town or city	From – To (in each place you visit)	Accommodation type e.g. Hotel/Backpackers/Cruise ship/Private	Urban	Rural
E.g.CHINA/Guangdong/Hong Kong	6 th Sept – 12 th Oct	Hotel/Private accommodation		

PAST TRAVEL HISTORY

Please list countries travelled to previously, and if possible, the years they were visited:

IMMUNISATION HISTORY

Please obtain any available immunisation records from your Doctor prior to your appointment if you are not registered at Ropata. If you have an International Certificate of Vaccination please bring it to your appointment.

To your knowledge are you fully immunised? ☐ Yes ☐ No

Were you born in New Zealand? ☐ Yes ☐ No

If not NZ born where were you born? _____

	Had disease	Vaccine Date	Not Known
Chickenpox (Varicella)			
Hepatitis A			
Hepatitis B			
Influenza			
Japanese Encephalitis			
Measles/Mumps/Rubella			
Meningococcal Meningitis			
Polio			
Pneumococcal Pneumonia			
Rabies			
Cholera			
Tetanus/Diphtheria			
Yellow Fever			
Typhoid			

I have had these Vaccines in the past four weeks

- ☐ Yellow Fever
☐ MMR

MEDICAL HISTORY

Do you have a pre-existing medical condition?

☐ Yes ☐ No

If answer is 'yes' please specify: _____

Are you a Smoker? ☐ Yes ☐ No

If yes please enter the amount smoked per day: _____

If you are taking any prescription medications, please write them in the box below with dosages.

Medication	Dose

Do you have any known allergies to the following:

☐ Eggs
☐ Yeast
☐ Antibiotics
☐ Other medications: _____

Weight in Kg: _____

Please tick if you have present or past history of the following:

☐ Psoriasis
☐ Psychiatric disorders/Depression
☐ Nightmares
☐ Seizures/Epilepsy
☐ Stomach/colon problems
☐ Cardiac problems
☐ Previous fainting or reaction to a vaccine?

If you have had a drug reaction, do you know the name of the vaccine? Can you describe the reaction?

- ☐ Have you had a thymectomy or tumour of the Thymus gland?
- ☐ Do you have any type of immune disorder? (Cancer, leukaemia etc)
- ☐ Spleen removal
- ☐ I take drugs that suppress my immune system
- ☐ Other: _____

WOMEN:

- | | | |
|---|------------------------------|-----------------------------|
| Are you pregnant? / Possible? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Breast Feeding | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you planning to become pregnant in the next three months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have a problem with recurrent yeast infections? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

MALARIA MEDICATION HISTORY

Have you ever taken any of the following anti-malarial medications?

- ☐ Larium
- ☐ Doxycycline
- ☐ Malarone
- ☐ Other: _____

I cannot remember the name of the medication but I travelled to:

When I took the Malaria medication:

- ☐ I had no problems and took it regularly
- ☐ I stopped taking it before I was advised to
- ☐ I had the following side effects:

- ☐ I had Malaria on return

Any other information you think we should know:

Do you require a prescription for travellers Diarrhoea: Yes ☐ No ☐

Where did you hear about us:

☐ Travel Agent

☐ Doctor

☐ Newspaper

☐ Other: _____

Thank you for completing this questionnaire.
Please return this to us by email: Travelmed@Ropata.net.nz fax it: 9200 873,
or drop it into us at 577 High Street, Lower Hutt.