Hairini
Medical Centre

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Address: 29A Hairini Street,
Hairini, Tauranga 3112

Clinic hours: Mon - Fri | 8:30 am - 5 pm

Travel Health Questionnaire

Before you head away, please complete this travel health questionnaire and return it to Hairini Medical Centre for a pre-assessment. Then we can book your travel health appointment. Complete all sections so that we can ensure we are able to provide you with the best medical advice for your trip.

YOUR DETAILS

Please complete all details

Surname:		First names:		
Age:	D.O.B:	Male: ◯	Female: ◯	Gender diverse: ◯
COMPLETE IF THE TRAVELER IS UNDER 16YRS AND YOU ARE A PARENT OR GUARDIAN				
Your Full Name:		Your relationship:		
Country of Birth:		Nationality:		
Address:				
City:		Postcode		
Home Phone:		Mobile		
Medical Centre:		GP Name:		

UPCOMING DETAILS

If you have a finalised itinerary, please attach it to this form or complete all details using your itinerary.

Date leaving New Zealand:	
Date returning to New Zealand:	
Planned activities i.e. rural, urban/cities, trekking, altitude, climbing, scuba diving, cycling, rafting, boating, other (specify):	
Detail the purpose of trip (holiday, visiting family/friends, business, medical/dental treatment, work, sport, expedition):	
Type of accommodation, i.e. camping, budget, backpackers, air conditioned hotel, private home, AirBnB, other (specify):	
Do you have travel insurance?	◯ Yes ◯ No Insurance Provider:

Unless itinerary is attached, please list in order the countries and their specific regions you intend on visiting?

Country / region 1	**Country / region 2**
Country / region 3	**Country / region 4**
Country / region 5	**Country / region 6**

CURRENT HEALTH & PREVIOUS TRAVEL HEALTH EXPERIENCES Please tick the box that applies for you and explain or specify in detail where requested		YES	NO
1.	Have you travelled previously to any less developed countries, e.g. Rwanda, India, Nepal, Afghanistan, Bangladesh, Cambodia, Myanmar, Peru, parts of South America	◯	◯
	If yes, specify:		
	If yes, did you have an illness while travelling? Please explain:		
Questions 2-18 are to be answered by ALL travellers.			
2.	Do you have or have you ever had any medical problems? i.e. Blood clots, asthma or any other breathing problems, chest problems, heart disease, renal/liver problems, migraine, high blood pressure, diabetes, stomach ulcer, psoriasis, joint/back problems, cancer, mastectomy, splenectomy, epilepsy, depression, schizophrenia, anxiety attacks, mental illness, weakness of the immune system, HIV/AIDS, or thyroid disorders?	◯	◯
	If yes, specify:		
3.	Do you have a family history of blood clots?	◯	◯
4.	Do you regularly take or occasionally take any medications? (Prescription and non-prescription) eg: contraceptive pill, antibiotics, migraine tablets, inhaler, vitamins	◯	◯
	If **yes**, list all medications:		
5.	Are you allergic to anything? i.e. sulphur drugs, penicillin, tetracycline, neomycin, gelatine, any foods including eggs, iodine, latex, band aids, insect bites?	◯	◯
	If yes, specify:		
6.	Have you been in hospital, been ill or injured in the last 6 weeks? If yes, outline:	◯	◯
7.	Are you currently undergoing or recently had any medical investigations/treatments? i.e. HIV, post-transplant, chemotherapy, steroid therapy, radio-iodine therapy?	◯	◯
	If yes, outline:		
8.	Have you had immune globulin or a blood transfusion in the last 12 months?	◯	◯
9.	Have you ever had hepatitis?	◯	◯
10.	Have you ever had COVID-19?	◯	◯
	If yes, when was your most recent infection?		

CURRENT HEALTH & PREVIOUS TRAVEL HEALTH EXPERIENCES Please tick the box that applies for you and explain or specify in detail where requested	YES	NO
11. Have you had any previous vaccinations?	◯	◯
If yes, list these including date/year of last dose:		

Vaccination	Date	Yes	No	Vaccination	Date	Yes	No	Vaccination	Date	Yes	No
Diphtheria/ Tetanus		◯	◯	Typhoid		◯	◯	Influenza		◯	◯
Hepatitis A		◯	◯	Hepatitis B		◯	◯	COVID-19		◯	◯
If yes, # of doses?				**If yes, # of doses?**				**If yes, # of doses?**			
MMR *(Mumps, Measles, Rubella)*		◯	◯	Rabies		◯	◯	Meningitis		◯	◯
If yes, # of doses?				**If yes, # of doses?**							
Yellow fever		◯	◯	Polio		◯	◯				

Questions 12-18 are to be answered by all travellers

12.	Have you received any vaccinations during the past four weeks?	◯	◯
13.	Are you about to be or recently under the care of any Medical or Surgical specialists?	◯	◯
14.	Are you breastfeeding, currently pregnant, or planning to become pregnant while travelling or within 3 months of your return?	◯	◯
15.	Have you ever had a serious reaction to a vaccination?	◯	◯
	If yes, specify:		
16.	Do you know what vaccines you need for this trip?	◯	◯
	If yes, outline:		
17.	Do you need a prescription for your usual medicines and/or additional medicines required for this trip?	◯	◯
	If yes, specify:		
18.	Do you have any further queries about health concerns or wellness needs during this trip?	◯	◯
	If yes, outline:		

Type your name here as a signature that confirms that all personal information is correct

Your / Parent / Guardian signature:

Your / Parent / Guardian name (print):

Date:

Note: Travel consultations are $90 per patient (excluding the cost of vaccines).
We do not provide Yellow Fever or Dukoral vaccines.
Prepayment may be required prior to ordering vaccines.