UFS Medical
Pre-Travel Assessment

Mr / Mrs / Ms / Dr / Miss   Surname.. First name...

Date of birth............../ ..../ .... Occupation ....

Contact Details

Mobile.. Home phone ....

Address .... Postcode ....

Medicare number ....

Expiry Date .... Reference No. ....

Trip Details

Date of Departure.............../ ..../ ....   Date of Return ..../ ..../..............

Countries to be visited	Cities to be visited	Duration of Stay

Please circle all the descriptions that describe your trip:

Type of Trip	Business	Pleasure	Other			
Holiday Type	Package	Self-Organised	Backpacking	Trekking	Camping	Cruise Ship
Accommodation	Hotel	Relatives	Hostel	Other		
Area Staying In	Urban	Rural	Altitude			
Activities	Safari	Adventure	Other			
Travelling	Alone	With Family	In a Group	Friend/s	Colleague	

Your Health - Current or Past
Please list any medications that you are currently taking:

Your Health - Current or Past *continued*

Do you OR have you had any of the following medical problems (please circle):

Asthma	Diabetes	High Blood Pressure	Leukemia
HIV/AIDS	Irregular Heartbeat	Splenectomy	Epilepsy
Heart Disease	Blood Clotting Disorder	Weakness of the Immune System	Transplant
Recent Chemotherapy/ Radiotherapy			

A. Any other medical problems?

B. Are you allergic to any of the following (please circle): **Eggs / Penicillin / Iodine**

Do you have any other allergies..

C. Have you ever felt faint or fainted after an injection or giving blood?   **Yes / No**

D. (Women only) Could you be, or are you planning to become pregnant within 3 months of your return?   **Yes / No**

E. Are you in contact with anyone with a weakened immune system?   **Yes / No**

F. Have you ever had a serious reaction to vaccine given to you before?   **Yes / No**

G. Have you even taken Malaria tablets? **Name**

Vaccination History
Please write the date next to vaccine. *Previous travel patients please record vaccinations given elsewhere since your last visit to our clinic.*

Tetanus	Whooping Cough / Tetanus	Polio
Influenza	Hepatitis A	Hepatitis B
Rabies	Yellow Fever	Measles, Mumps, Rubella
Japanese Encephalitis	Typhoid	Varicella (Chicken Pox)

Signature .... Date .... /............. /...............