



Pre-travel Questionnaire

Please complete this form in full and send to the
Travel Team at Waikanae Health prior to your consultation.

Waikanae Health
Marae Lane
Waikanae 5036
New Zealand
Tel: 04 293 6005
Fax: 04 293 8005

Full name: _____ Date of birth: _____ Sex: Male / Female

Address: _____

Phone numbers Daytime: _____ Afterhours: _____

Email address: _____ My usual Doctor is: _____

Travel dates: _____ to _____

Countries I am visiting: (please be specific about regions/areas of the counties) _____

Purpose of trip - business, holiday, guided tour, safari, expedition, volunteering work, visiting friends/relatives:

other: _____

Accommodation - hotels/motels, youth hostels/backpackers, camping, staying with friends/relatives: _____

Higher-risk activities e.g. SCUBA diving, other water-sports, climbing to altitude above 2500m. Please state: _____

Past medical history - serious illness or operations, mental health issues: _____

History of deep vein thrombosis or pulmonary embolus: Yes/No

Medications: (Regularly taken - please indicate dose. Standby treatment e.g asthma inhaler) _____

Allergies: (Medications, animal fur, pollen/grass, insect bites/stings, foods or anything else) _____

Woman - contraception: _____ Current or planned pregnancy: Yes/No

Are you travelling for the purpose of seeking medical or dental treatment? Yes/No

Previous vaccination history: (Your doctor may be able to print off a record of this - bring it with you)

Are you up to date with routine childhood immunisations? Yes/No

What travel vaccinations have you had previously and when? _____

Signed: _____ Date: _____

Please send the completed form to the **Travel Team at Waikanae Health** Fax: 04 293 8005
or email: nurse@waikanaehealth.co.nz and we will contact you to make an appointment.