# FOUNTAIN GATE MEDICAL CENTRE

151 KURRAJONG RD • NARRE WARREN VIC • 3805
PHONE: (03) 9704 8011 • FAX: (03) 9704 1841

CERTIFIED MEMBER

**PLEASE USE BLOCK LETTERS**

## YOUR DETAILS:

**Mr/Mrs/Miss/Master** **Date: ___/___/20__**

**First Name _____Last Name_____Age_____Sex M□ F□**

**Date of Birth_____Country of Birth_____Nationality_____**

**Contact Address_____**

**Suburb _____Postcode_____Mobile Ph_____**

**Email_____Daytime Phone No_____**

**Medicare No_____Exp:_____/_____Ref No_____**

**Pension No_____Exp_____/_____**

**Do you have private health fund extras cover for pharmaceutical benefits? Yes □ No □**

**Emergency Contact_____Phone No _____**

**Relationship to you _____**

## YOUR HEALTH:

- **Have you travelled to less developed countries before? Yes □ No □**

**Please describe any health problems you had while away_____**

- **Have you ever had any serious medical problems e.g. asthma, chronic lung disease, diabetes, stomach ulcer, splenectomy, thmectomy, epilepsy, heart disease, high blood pressure, irregular heartbeat, depression, schizophrenia, anxiety or panic attacks, mental illness, weakness of the immune system, HIV/AIDS, blood clotting disorders, thrombosis, clots in lungs, or other?**

  **Yes □ No □**

**If yes, please specify_____**

**Have you been in hospital in the last 6 weeks or planning this in the next 6 weeks? Yes □ No □**

- **Are you taking any regular medication? Yes □ No □**

  **Please specify_____**

- **Are you allergic to anything e.g. sulphur drugs, eggs, penicillin, bee stings, iodine, gelatine, neomycin, latex, band aids, other? Yes □ No □**

  **If yes, please specify_____**

- **Women only: Are you breast feeding, or could you be pregnant now, or plan to become so, within 3 months of your return? Yes □ No □**
- **Did you miss any of the usual childhood vaccines? Yes □ No □**

## YOUR TRIP

**Do you have any particular health concerns regarding this trip? Yes □ No □**

**If yes please outline: _____**

**Please list in order the countries you intend visiting and how long (in weeks) you plan to spend in each:**

1. **_____Weeks _____**
2. **_____ Weeks_____**
3. **_____ Weeks_____**
4. **_____ Weeks_____**
5. **_____ Weeks_____**

**YOU MUST BRING VACCINE RECORDS FROM YOUR DOCTOR IF YOU HAVE HAD ANY PREVIOUS TRAVEL VACCINES**

**Travel vaccines you have already had? Please tick and indicate when:**

**Hepatitis A □_____Tetanus□ _____Yellow Fever □ _____**

**Hepatitis B □ _____Polio □ _____Cholera □ _____**

**Flu □ _____Typhoid □ _____Meningococcal □ _____**

**Date leaving Australia? _____Returning to Australia? _____**

## OTHER

**How did you learn of this Travel Clinic? Please tick:**

**Been to this Clinic before □ Friend/Relative □ Work Colleague □ Doctor □**

**Travel Agent □ Name _____**

**Yellow Pages □ On-line Yellow Pages □ White Pages □ Our Website □ Google □**

**Other source of referral: _____**

**You may wish to subscribe to the Travel Medicine Alliance newsletter. If so, visit www.travelmedicine.com.au. Newsletter subscription option is on the left hand side.**

## PATIENT PRIVACY CONSENT

**I have read and understand the Clinic Privacy Policy.**

**Your signature: _____**

**Or if signature of parent or guardian, relationship to patient: _____**

## THANK YOU. PLEASE GIVE THIS FORM TO THE RECEPTIONIST.