Travellers' Health & Vaccination Clinic (THVC)

PRE-TRAVEL CONSULTATION: PATIENTS, PLEASE COMPLETE PAGE 1

PERSONAL PARTICULARS Last THVC visit: _____

Gender: M / F Name: _____

NRIC / FIN / Passport: _____ Profession: _____

Date of birth: _____ Race: _____ Nationality: _____

Marital status: _____ Age: _____ Country of birth: _____

Address: _____

☐ No change _____ Postal Code: _____

Mobile number: _____ Home: _____ Office: _____

Email (if preferred): _____

TRAVEL DESTINATION:	**Urban/ Rural**	**Departure Date:**	**Return Date / Duration:**
	☐ ☐		
	☐ ☐		
	☐ ☐		

PURPOSE OF TRIP:
- ☐ Business
- ☐ Holiday
- ☐ Volunteer
- ☐ Education

ACCOMODATION:
- ☐ Hotel
- ☐ Cruise
- ☐ Hostel / Tent
- ☐ Friend / Relative

CLINIC VISIT FOR:
- ☐ Vaccines
- ☐ Malaria
- ☐ Altitude illness
- ☐ Employer / University form

MEDICAL HISTORY:
- ☐ Hypertension
- ☐ Diabetes
- ☐ Asthma / COPD
- ☐ Liver disease
- ☐ Kidney disease
- ☐ HIV infection
- ☐ Heart disease / Stroke
- ☐ Blood clot / DVT
- ☐ Autoimmune disorder
- ☐ Myasthenia gravis / thymus disorder
- ☐ Cancer _____
- ☐ Other _____
- ☐ Cardiac arrhythmia
- ☐ Seizure
- ☐ Psychiatric illness
- ☐ Depression / Anxiety
- ☐ Surgery: _____

MEDICATIONS: _____

WITHIN PAST 6 MONTHS:
- ☐ Steroid medications
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Other immunosuppressive therapy

ALLERGY: None / Egg Allergy / Other _____

FEMALE ONLY: Last menstrual period: _____
- ☐ Pregnant
- ☐ Breastfeeding
- ☐ Planning pregnancy
- ☐ Oral contraceptives
- ☐ Post-menopausal
- ☐ Irregular cycle
- ☐ Child

VACCINATION HISTORY: Please tick all vaccines you have had and list dates

☐ Cholera	☐ MMR (Measles/mumps/rubella)
☐ Diphtheria/tetanus (DTP/Td)	☐ Meningococcal
☐ HPV (Gardasil)	☐ Pneumococcal
☐ Hepatitis A	☐ Polio
☐ Hepatitis B	☐ Rabies
☐ Hep A&B (Twinrix)	☐ Typhoid
☐ Influenza	☐ Varicella (chickenpox)
☐ Japanese Encephalitis	☐ Yellow Fever