The Woods MEDICAL CENTRE
SKIN CANCER CLINIC & GENERAL PRACTICE

97 SCARBOROUGH BEACH RD, SCARBOROUGH WA 6019
Phone: 08 9245 1912 Fax: 08 9245 5260

TRAVEL ASSESSMENT FORM

Family Name		Given Name	
Date of Birth		Gender	
Occupation		Country of Birth	
Home Address			
Phone		Email	

Travel Information

Date of departure		Date of return	
Country (in order of visit)	**Duration** (weeks)	**Type of accommodation planned** (hotel / hostel / homestay / camping)	

Main reason for travel	Holiday	☐ Yes ☐ No	Visit Friends / Relatives	☐ Yes ☐ No
	Business	☐ Yes ☐ No	Volunteering	☐ Yes ☐ No
Do you plan to travel to rural areas?				☐ Yes ☐ No
Do you plan to do activities in remote or wilderness areas?				☐ Yes ☐ No
Will anyone else be travelling with you?		☐ Yes ☐ No	If yes, age/s	
Have you previously travelled overseas?		☐ Yes ☐ No		
If yes, which of the following regions have you travelled to?	☐ Africa ☐ Middle East ☐ Europe ☐ Asia ☐ North America ☐ Central / South America ☐ Pacific Islands ☐ Other_____			

Health Information

In which country/countries did you spend your childhood?	
Did you complete the recommended childhood vaccinations?	☐ Yes ☐ No
Are you allergic to eggs, medications or other substances?	☐ Yes ☐ No
List ALL allergies	
List ALL medications you are currently taking	
List past significant medical/health problems	

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Do you have or have you had any of the following diseases?

Hepatitis	☐ Yes ☐ No	Deep vein thrombosis (DVT) or blood clots	☐ Yes ☐ No
Organ Transplant	☐ Yes ☐ No	Leukaemia, lymphoma or other cancer	☐ Yes ☐ No
HIV / AIDS	☐ Yes ☐ No		

Vaccination History

Indicate whether you have had the following vaccines, the approximate year received and any adverse reactions. Check with your GP or previous medical records to find this information.

Vaccine	Year	Adverse reactions or comments
BCG		
Cholera		
Hepatitis A		
Hepatitis B		
Influenza (seasonal or H1N1)		
Japanese Encephalitis		
Measles/mumps/rubella		
Meningococcal		
Pneumococcal		
Polio		
Q fever		
Rabies		
Tetanus/Diphtheria/Pertussis		
Typhoid		
Varicella (chicken pox)		
Yellow fever		
COVID Vaccination	1st Dose _____2nd Dose____ 3rd Dose____ 4th Dose____ (please tick)	
	Date of last dose:	

Have you ever fainted or felt unwell soon after an injection?	☐ Yes ☐ No
Female only: Are you pregnant or trying to become pregnant?	☐ Yes ☐ No
Female only: Are you breastfeeding?	☐ Yes ☐ No
Have you ever been tested for TB? (Mantoux test, Quantiferon)	☐ Yes ☐ No
Have you previously received anti-malarial drugs?	☐ Yes ☐ No
If yes, provide details of drug taken, duration and any adverse reactions	

COMMENTS

Patient Name (PRINT):	Signature:	Date:
_____	_____	_____