CHROMIS
All health matters in OHS

Health Questionnaire for International Travel

Chromis Travel Medicine **www.chromis.com.au**
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The detailed information we require is necessary to enable us to give you individual advice tailored to your specific travel arrangements and health.

Your Personal Details

Surname		First Name	
Date of Birth		Age	Gender ☐ M ☐ F
Contact Address			
Suburb			Postcode:
Phone (H)	Phone (W)		Mobile
Email:			
Nationality:	Country of Birth:		
My GP/Doctor is (Name & Suburb):			
Medicare Number: _____ Ref: _____ Exp: _____			
My Private Health Fund is:			
Do you consent to send vaccination history to Australian Immunisation Register (please circle) Y / N			

If your visits are being paid by your employer please complete the following:

Name of Company and address:

_____

How did you hear about Chromis Travel Medicine?

☐ Friend/relative	☐ Work Colleague	☐ Chromis Website	☐ TMA Website
☐ Yellow pages	☐ White pages	☐ Travel agent (name)	
☐ Doctor (name)		☐ Been to Chromis before	
☐ Other (please state)			

Dates of your Trip

Date of Departure: _____ Return Date_____

Countries to be visited	Cities or areas to be visited	Length of stay

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Please circle all the descriptions that describe your trip

1 Type of Trip	Business	Pleasure	Other
2 Holiday Type	Package	Self-Organised	Backpacking
	Camping	Cruise Boat	Trekking
3 Accommodation	Hotel	Relatives	Other
		Family Home	
4 Travelling	Alone	With Family	In a Group
		Friend	
5 Staying in Area	Urban	Rural	Altitude
6 Activities	Safari	Adventure	Other

Your Health – Current or Past

Do you have OR have you had any of these medical problems (please circle)

asthma	**chronic lung disease**	**tendency to chest infections**	**diabetes**
stomach ulcer	**irregular heartbeat**	**joint problems**	**psoriasis**
heart disease	**blood clotting disorders**	**weakness of the immune system**	**HIV/AIDS**
mastectomy	**high blood pressure**	**mental illness (incl anxiety/panic)**	**splenectomy**
liver disease	**epilepsy**	**kidney disease**	**cancer**

a) Any other medical problems (please specify)_____

b) List any current or repeat medication you are taking now *(eg contraceptive pills, antibiotics)*_____

_____

c) Are you allergic to any of these? *(please circle)* eggs, bee stings, sulphur drugs, penicillin/neomycin, iodine, latex, bandaids

d) Do you have any other allergies? *(please specify*_____ **e)**

Have you ever felt faint or fainted after an injection or giving blood?_____ ☐ Yes ☐ No

f) Women only, could you be pregnant now OR do you plan to become pregnant within 3 months of your return?..... ☐ Yes ☐ No

g) Are you in contact with anyone with a weakened immune system?

h) Eg people with AIDS, cancer sufferers on chemotherapy, people taking steroid drugs..... ☐ Yes ☐ No

i) Have you ever had a serious reaction to a vaccine given to you before?..... ☐ Yes ☐ No

Vaccination or Disease History and when.

Tetanus ☐	Hepatitis B ☐	Polio ☐
Typhoid ☐	Yellow Fever ☐	Hepatitis A ☐
Meningitis ☐	Jap B Enceph ☐	Influenza ☐
Rabies ☐	Whooping Cough ☐	Measles ☐
Varicella ☐	Mumps ☐	Malaria Tabs ☐