

Chromis Travel Medicinewww.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 <input type="checkbox"/> M <input type="checkbox"/> F
Contact Address			
Suburb		Postcode:	
Phone (H)	Phone (W)	Mobile	
Email:			
Nationality:		Country of Birth:	
My GP/Doctor is (Name & Suburb):			
My Private Health Fund is:			

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?

<input type="checkbox"/> Friend/relative	<input type="checkbox"/> Work Colleague	<input type="checkbox"/> Chromis Website	<input type="checkbox"/> TMA Website
<input type="checkbox"/> Yellow pages	<input type="checkbox"/> White pages	<input type="checkbox"/> Travel agent (name)	
<input type="checkbox"/> Doctor (name)		<input type="checkbox"/> Been to Chromis before	
<input type="checkbox"/> 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



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 <input type="checkbox"/>	Hepatitis B <input type="checkbox"/>	Polio <input type="checkbox"/>
Typhoid <input type="checkbox"/>	Yellow Fever <input type="checkbox"/>	Hepatitis A <input type="checkbox"/>
Meningitis <input type="checkbox"/>	Jap B Enceph <input type="checkbox"/>	Influenza <input type="checkbox"/>
Rabies <input type="checkbox"/>	Whooping Cough <input type="checkbox"/>	Measles <input type="checkbox"/>
Varicella <input type="checkbox"/>	Mumps <input type="checkbox"/>	Malaria Tabs <input type="checkbox"/>