## **Travel Questionnaire**

## **Please fill out this form with as much detail as possible. We will confirm the accuracy of the details when you attend your appointment.**

## **Personal Details (fields marked with a red asterisk are compulsory)**

**Name \*** …………………………………………………………………………………………………………………………………………………………………. **Date of Birth \*** …………………………………………………………………………………………………………………………………………………………………. **Daytime Telephone** \* …………………………………………………………………………………………………………………………………………………………………. **Email \*** …………………………………………………………………………………………………………………………………………………………………. **Gender**

………………………………………………………………………………………………………………………………...................................

**Postcode \*** ………………………………………………………………………………………………………………………………………………………………….

## **Trip Dates**

**Departure \*** …………………………………………………………………………………………………………………………………………………………………. **Return \*** ………………………………………………………………………………………………………………………………………………………………….

**Duration \***

………………………………………………………………………………………………………………………………………………………………….

## **Itinerary (list all countries you will be visiting)**

**Country \*** …………………………………………………………………………………………………………………………………………………………………. **Duration \*** …………………………………………………………………………………………………………………………………………………………………. **Availability of Medical Help** (If you are travelling to a place where medical help is not readily on hand, estimate how long it would take to reach a doctor) ………………………………………………………………………………………………………………………………………………………………….

**Country \*** …………………………………………………………………………………………………………………………………………………………………. **Duration \*** …………………………………………………………………………………………………………………………………………………………………. **Availability of Medical Help** (If you are travelling to a place where medical help is not readily on hand, estimate how long it would take to reach a doctor) …………………………………………………………………………………………………………………………………………………………….

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## **Trip Description: please tick all appropriate boxes**

**Purpose of Trip:**

☐ Business ☐ Pleasure ☐ Other

**Type of Trip:**

☐ Package ☐ Self-Organised ☐ Backpacking ☐ Camping ☐ Cruise Ship ☐ Trekking

**Accommodation:**

☐ Hotel ☐ Friends/Family ☐ Other

**Travelling:**

☐ Alone ☐ With Friend/Family ☐ In a Group

**Location Type:**

☐ Urban ☐ Rural ☐ Altitude (over 3000m or 10,000ft)

**Activity Type:**

☐ Safari ☐ Adventure ☐ Other

## **Personal Medical History**

**List all chronic medical conditions that you have (eg. diabetes, heart or lung conditions)** …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. ………………………………………………………………………………………………………………………………………………………………….

**List all allergies that you have (eg. eggs, nuts, antibiotics**) …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. ………………………………………………………………………………………………………………………………………………………………….

**If you have had a serious reaction to a vaccine in the past, which vaccine was it?** …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. ………………………………………………………………………………………………………………………………………………………………….

**List all of your current medications (including oral contraception)** …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. ………………………………………………………………………………………………………………………………………………………………….

**Please tick to confirm ‘yes’:**

**☐ Have you recently suffered from any infection (e.g heavy cold, flu or high temperature)?**

**☐ Does having an injection cause you to feel faint?**

**☐ Do you or any close family members have epilepsy?**

**☐ Do you have any history of mental illness including depression or anxiety?**

**☐ Have you recently undergone radiotherapy, chemotherapy or steroid treatment?**

**☐ Have you taken out travel insurance?**

**☐ If you have a medical condition, have you told your insurance company about it?**

**☐ Are you pregnant, planning pregnancy or breast feeding?**

**Write below any further information that might be relevant** …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………………………………………………. ………………………………………………………………………………………………………………………………………………………………….

**Have you ever had any of the following vaccinations / tablets and if so, when?**

## **Vaccination History**

**Tetanus**

…………………………………………………………………………

**Diphtheria**

…………………………………………………………………………

**Hepatitis A**

…………………………………………………………………………

**Meningitis**

…………………………………………………………………………

**Influenza**

…………………………………………………………………………

**Jap B Enceph**

…………………………………………………………………………

**Malaria Tablets**

………………………………………………………………………….

**Please ensure you complete this form before coming to see the nurse.**

**If you have any queries, please contact us**

**Polio**

…………………………………………………………………………

**Typhoid**

…………………………………………………………………………

**Hepatitis B**

…………………………………………………………………………

**Yellow Fever**

…………………………………………………………………………

**Rabies**

…………………………………………………………………………

**Tick Borne**

…………………………………………………………………………

**Other**

…………………………………………………………………………

…………………………………………………………………………

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