Travel Health Questionnaire

Date Form Issued: ____________
Date Form Returned: ____________

Please complete a form for each member of your party

Please return the completed questionnaire
at least eight weeks prior to your date of departure

Personal Details

Name: ____________________ Title: ____________________

Date of Birth: ____________________ Male/Female: ____________________

Home Tel. No: ____________________ E-mail: ____________________

Mobile Tel. No: ____________________ Do you wish to be contacted by this method: **YES/NO**

Date of Departure: ____________________ **Return Date or Length of Trip:** ____________

Itinerary and Purpose of Visit

	Country to be Visited	Town to be Visited	Length of Stay	How Close to Medical Help at Destination/ Remote?
1.				
2.				
3.				

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:	❒
Activity Type:	Safari:	❒	Adventure:	❒	Other:	❒

Do Any of the Following Apply to You? * Please tick as appropriate

I am pregnant/or plan to become pregnant within three months of travel:	**YES:**	❒	**NO:**	❒
I am taking steroids or have had a joint injection for pain within last three months:	**YES:**	❒	**NO:**	❒
I am suffering from a disease of the immune system:	**YES:**	❒	**NO:**	❒

I am allergic to drugs or food (e.g. eggs): **Please Specify:** ____________________

Have you ever taken medication for:					
	Epilepsy:	**YES:**	❒	**NO:**	❒
	Depression:	**YES:**	❒	**NO:**	❒
	Skin Complaints:	**YES:**	❒	**NO:**	❒

Please list any medical condition requiring regular supervision or medication: ____________________

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Vaccination History (please bring any evidence of previous vaccines to appointment)

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

Tetanus:	❐	Date: ____________	Polio:	❐	Date: ____________	Diphtheria:	❐	Date: ____________
Typhoid	❐	Date: ____________	Hepatitis A:	❐	Date: ____________	Hepatitis B:	❐	Date: ____________
Meningitis	❐	Date: ____________	Yellow Fever:	❐	Date: ____________	Influenza	❐	Date: ____________
Rabies:	❐	Date: ____________	Jab C Enceph:	❐	Date: ____________	Tick Borne:	❐	Date: ____________
Malaria Tablets	❐	Date: ____________						