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)

………

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)

……

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)

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

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

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List all of your current medications (including oral contraception)

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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

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Vaccination History

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

Tetanus

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Polio

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Diphtheria

………………………………………………………………………………

Typhoid

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Hepatitis A

………………………………………………………………………………

Hepatitis B

………………………………………………………………………………

Meningitis

………………………………………………………………………………

Yellow Fever

………………………………………………………………………………

Influenza

………………………………………………………………………………

Rabies

………………………………………………………………………………

Jap B Enceph

………………………………………………………………………………

Tick Borne

………………………………………………………………………………

Malaria Tablets

………………………………………………………………………………

Other

………………………………………………………………………………

………………………………………………………………………………

………………………………………………………………………………

Please ensure you complete this form before coming to see the nurse.
If you have any queries, please contact us:

Altrincham Medical Practice
Lloyd House,
7 Lloyd Street,
Altrincham WA14 2DD
Tel: 0161 928 2424