OUGHTIBRIDGE SURGERY

CHURCH STREET, OUGHTIBRIDGE,
SHEFFIELD, S35 0FW
TELEPHONE 0114 2299835

Pre-Travel Questionnaire

Please provide as detailed answers as possible. All information is treated in strictest confidence.

Personal Details

Name:…… Date of Birth: DD/MM/YYYY
Correspondence Address: ……
……
Telephone no.: (Mobile:……
Home):……..…
E-mail address:……

Travel Details

Date of departure: DD/MM/YYYY Date of return: DD/MM/YYYY

Destination(s): *(please include **all** anticipated destinations)*

Country	Town/Region	Urban/Rural	Accommodation	Duration
e.g. Nepal	Lhasa	Rural	C	5 days

Accomodation: Camping=C, Hotel=H. Friends/Family=F, Backpacking/Hostels=B, Other=O

Purpose of Travel	Please Tick	Activities	Please Tick
Holiday	□	Trekking/Camping	□
Business	□	Backpacking/Overlanding	□
Religion	□	Package holiday	□
Medical elective	□	Cruise ship	□
Aid work	□	Climbing/High altitude	□
Visiting friends and/or family	□	Safari	□
Other *(please state):*		Healthcare work	□
……..……	□	Sports/Diving	□
……..……	□	Other	□

Pre-Travel Questionnaire

(continued)

Travel Planning *(please tick one)*:

Are you travelling: Alone □, with family and/or friend(s) □, in a group □?

Have you organised your trip: by yourself □, through a travel agent □, through a voluntary organisation □, through work □, or other □?
(please state):……..

Medical History

Do you have any medical conditions that may affect your trip? Yes □ No □
If yes, please state: ……
……
……
……

Do you take any regular medication (including inhalers)? Yes □ No □
If yes, please state: ……
……
……
……

Do you have any allergies to:
Medications Yes □ No □ *If yes, please state:* ……..
Food Yes □ No □ *If yes, please state:* ……..
Eggs Yes □ No □ *If yes, please state:* ……..
Other Yes □ No □ *If yes, please state:* ……..

Women only

Are you pregnant, planning pregnancy or breast feeding? Yes □ No □
Do you use an oral contraceptive pill? Yes □ No □
If yes, which one: ……

Vaccination History

As far as you are aware, did you receive the normal childhood vaccination schedule in the United Kingdom? Yes □ No □

Have you ever had a reaction to any vaccines/immunisations? Yes □ No □
If yes, please state: ……

Pre-Travel Questionnaire

(continued)

Please indicate which of the following vaccinations you have previously received. (If known)

Vaccine	Last received *(please tick)*		
	Full course	**Booster**	**Date received**
DTP *(Diphtheria, Tetanus, Polio)*	□	□	DD/MM/YYYY
TD *(Tetanus, Diphtheria)*	□	□	DD/MM/YYYY
Tetanus alone	□	□	DD/MM/YYYY
Typhoid	□	□	DD/MM/YYYY
Hepatitis A	□	□	DD/MM/YYYY
Hepatitis B	□	□	DD/MM/YYYY
Meningococcal Group C	□	□	DD/MM/YYYY
Meningococcal Group A, C, Y, W135	□	□	DD/MM/YYYY
Pneumococcal	□	□	DD/MM/YYYY
Yellow Fever	□	□	DD/MM/YYYY
Influenza *('flu')*	□	□	DD/MM/YYYY
Rabies	□	□	DD/MM/YYYY
BCG *(for tuberculosis)*	□	□	DD/MM/YYYY
Others *(please state)*:			DD/MM/YYYY
……..	□	□	DD/MM/YYYY
……..	□	□	DD/MM/YYYY

Insurance *(please tick)*

Have you taken out travel health insurance? Yes □ No □

Are there any specific questions relating to you health during travel that you would like answered? *(please state)* ……..……..……
……..……
……..……
……..……

Please read and sign below the following statement:

I certify that the above answers are true to my knowledge, and that the advice and vaccination recommendations I receive will be influenced by the answers I have provided.

Signature:…….. Date……
Name *(please print)*: ……..

Thank you.