Fountains Medical Practice

Travel Questionnaire

PERSONAL DETAILS:

Name: **Sex:** **Male** **Female**

Date of Birth: **Postcode:**

Daytime Tel: **Email:**

TRIP DATES & ITINERARY

Departure: **Duration:**

Country & Region Travelling to: **Duration:**

TRIP DESCRIPTION – PLEASE TICK ALL THE APPROPRIATE BOXES:

Purpose of Trip:	☐ **Business**	☐ **Pleasure**	☐ **Other**
Type of Trip:	☐ **Package**	☐ **Self-Organised**	☐ **Backpacking**
	☐ **Camping**	☐ **Cruise Ship**	☐ **Trekking**
Travelling:	☐ **Alone**	☐ **With Friend/Family**	☐ **In a Group**
Location Type:	☐ **Urban**	☐ **Rural**	☐ **Altitude**
Activity Type:	☐ **Safari**	☐ **Adventure**	☐ **Other**

PERSONAL MEDICAL HISTORY

List all chronic medical conditions that you have (e.g. diabetes, heart or lung conditions)

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

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PERSONAL MEDICAL HISTORY

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)

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

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

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

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

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

Have you taken out travel insurance? ☐ Yes

If you have a medical condition have you told your insurance company? ☐ Yes

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

Please write below any further information that might be relevant

VACCINATION HISTORY

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

Tetanus	☐ Yes		Polio	☐ Yes	
Diphtheria	☐ Yes		Typhoid	☐ Yes	
Hepatitis A	☐ Yes		Hepatitis B	☐ Yes	
Meningitis	☐ Yes		Yellow Fever	☐ Yes	
Influenza	☐ Yes		Rabies	☐ Yes	
Jap B Enceph	☐ Yes		Tick Bone	☐ Yes	
Malaria	☐ Yes		Other		