

Travel Health Questionnaire

Personal Information

Title:

First names:

Surname:

Date of Birth:

Contact Details:

Home Telephone number:

Work Telephone number:

Mobile telephone number:

Your GP, Address and Tel Number:

Travel Information

Date of Departure:

Date of Return or overall length of trip:

| Country to be visited | Length of stay | Away from medical help? If so how remote? |
|-----------------------|----------------|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

Personal Medical History

Do you have any past medical history of note – in particular, epilepsy, fits, etc?

List any current medication

Do you have any known allergies – for example to eggs, antibiotics, nuts?

Have you ever had a serious reaction to a vaccine?

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

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Are you pregnant or planning a pregnancy?

Is there any other information that you think might be relevant?

Vaccination History

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

| | | | | | |
|-------------------|--|----------------------------------|--|------------------------------------|--|
| Tetanus | | Polio | | Diphtheria | |
| Typhoid | | Hepatitis A | | Hepatitis B | |
| Meningitis | | Yellow Fever | | Influenza | |
| Rabies | | Japanese Encephalitis | | Tick Borne Encephalitis | |

Other?

Malaria Tablets?