Travel Questionnaire – Market Street Medical Practice

Personal Details			
Name		Date of Birth	
Address			
Male / Female			
Phone Numbers	Home;	Work;	Mobile;
Email address			
Are you a registered patient with Market Street Medical Practice? Yes No			

Trip Dates	
Departure Date	Duration of travel

Trip Itinerary; please be as specific as possible in terms of cities/countries being visited eg not just 'Africa'

Country	Duration	Availability of Medical Help (i)

Trip Description – please tick all appropriate boxes

Purpose of Trip	○ Business	○ Pleasure	○ Other
Type of Trip	○ Package	○ Self organised	○ Back packing
	○ Camping	○ Cruise Ship	○ Trekking
Accommodation	○ Hotel	○ Friends/family	○ Other
Travelling	○ Alone	○ With family/friend	○ Part of a group
Location Type	○ Urban	○ Rural	○ Altitude (i)
Activity Type	○ Safari	○ Adventure	○ Other

Personal Medical History
List all chronic medical conditions that you have eg diabetes, heart or lung conditions;
List all allergies that you have;
If you have had a serious reaction to a vaccine in the past, which vaccine was it?
List all your current medications including contraception;
Have you recently suffered from any infection (eg heavy cold, flu or high temperature? Yes / No
Does having an injection cause you to feel faint? Yes / No

Do you or any of your close family members have epilepsy?	Yes / No
Do you have any history of mental illness including depression and anxiety?	Yes / No
Have you recently undergone chemotherapy, radiotherapy or steroid treatment?	Yes / No
Have you taken out travel insurance?	Yes / No
If you have a medical condition, have you told your insurance company about it?	Yes / No
Are you pregnant, planning pregnancy or breast feeding?	Yes / No
Please detail any further information you feel may be of relevance;	

Vaccination History - have you ever had any of the following vaccinations/tablets. If yes, please give the date;

Tetanus	Yes / No	Date		Polio	Yes / No	Date		Nurse comments
Diphtheria	Yes / No	Date		Typhoid	Yes / No	Date		
Hepatitis A	Yes / No	Date		Hepatitis B	Yes / No	Date		
Meningitis	Yes / No	Date		Yellow Fever	Yes / No	Date		
Influenza	Yes / No	Date		Rabies	Yes / No	Date		
Jap B Enceph	Yes / No	Date		Tick Bourne	Yes / No	Date		
Malaria Tablets	Yes / No	Date		Other	Yes / No	Date		