TOPCLIFFE SURGERY TRAVEL QUESTIONNAIRE

Please complete & return to reception

Name_____Date of Birth_____

Telephone/ Mobile Number._____

Date of start of trip_____

Return date/ Duration of trip_____

Country to be visited	Length of stay	How far or remote from medical care?
1		
2		
3		
4		

Please tick as appropriate to best describe your trip

Type of trip	Business		Pleasure		Other	
	Package		Self organised		Backpacking	
Type of holiday	Camping		Cruise ship		Trekking	
Accommodation	Hotel		Relatives/ family		Other	
Travelling	Alone		Family/ friends		Group	
Staying in area which is	Urban		Rural		Altitude	
Planned activities	Safari		Adventure		Other	

Do you have any allergies e.g. to eggs. Nuts or antibiotics?_____

Have you had a serious reaction to a vaccine before?_____

Do you or a close family member have epilepsy?_____

Do you have a past history of mental illness, depression or anxiety?_____

Have you recently had radiotherapy, chemotherapy or steroid treatment?_____

WOMEN ONLY - Are you pregnant, planning a pregnancy or breast feeding?_____

What vaccines/ Malaria tablets have you had before and when?

Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick borne	
Other			Malaria tabs		

Any other information which may be relevant? _____

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