# Wootton Medical Centre

## TRAVEL HEALTH QUESTIONNAIRE

Please complete a form for each patient travelling and return to Reception & book a travel consultation with a Practice Nurse.

| Personal Details: | | |
|---|---|---|
| **Title:** | **Full name:** | |
| **Date of birth:** | **Home telephone no:**<br><br>**Mobile telephone no:** | |
| **Itinerary & Purpose of Visit:**<br>**(please bring details to your appointment)** | | |
| **Date of departure:** | **Complete length of trip:** | |
| **Country & places / cities / villages to be visited:** | **Length of stay:** | **How close to medical help at destination?** |
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **Type of Trip:**<br>**(please provide details below to best describe your trip)** | | |
| **Business / Holiday / Other, please provide details:** | | |
| **Type of trip:** | **Packing / Self-organised / Backpacking / Camping / Cruise ship / Trekking / Honeymoon / Volunteer work (please specify) / Other (please specify):** | |
| **Accommodation:** | **Hotel / Camping / Family or friends home / Other (please specify):** | |
| **Travelling:** | **Group / With family or friend/s / Alone:** | |
| **Staying in area which is:** | **Main city / Rural / Altitude:** | |
| **Planned activities:** | **Safari / Adventure / Other (please specify):** | |
| **Any other information we should know about your trip:** | | |

| Do any of the following apply to you? | |
|---|---|
| **I am pregnant / breastfeeding / plan to become pregnant within 3 months of travel:** | ☐ **Yes** ☐ **No** |
| **I am taking steroids or have had a joint injection for pain within the last 3 months:** | ☐ **Yes** ☐ **No** |
| **I have a problem with my immune system:** | ☐ **Yes** ☐ **No**<br>**If yes, please specify:** |
| **I am allergic to drugs or food (e.g. eggs or chicken):** | ☐ **Yes** ☐ **No**<br>**If yes, please specify:** |
| **I have had a previous allergy to a vaccination:** | ☐ **Yes** ☐ **No**<br>**If yes, please specify:** |
| **Have you ever suffered with:**<br>• **Epilepsy:**<br>• **Depression**<br>• **Skin complaints:**<br>• **Recent / current chemo / radiotherapy:** | ☐ **Yes** ☐ **No**<br>☐ **Yes** ☐ **No**<br>☐ **Yes** ☐ **No**<br>☐ **Yes** ☐ **No**<br>**If yes, please specify:** |
| **Please list any medical conditions (past / current:** | |
| **Please list any regular medication you are taking:** | |

| Vaccination History:<br>(please provide dates for the following vaccinations / malaria tablets) | | | | | |
|---|---|---|---|---|---|
| **Tetanus:** | | **Polio:** | | **Diphtheria:** | |
| **Typhoid:** | | **Hepatitis A:** | | **Hepatitis B:** | |
| **Meningitis:** | | **Yellow Fever:** | | **Influenza:** | |
| **Rabies:** | | **Jap B Enceph:** | | **Tick Borne:** | |
| **Chloera:** | | **MMR:** | | **BCG** | |
| **Malaria Tablets:** | | **Other (please specify):** | | | |