Conway Road Medical Practice

Travel Questionnaire

Personal Details			
Name:		Sex:	Female / Male
Date of Birth:		Postcode:	
Daytime Tel:			
Email:			
Trip Dates			
Departure:		Duration:	
Itinerary			
Country	Duration	Availability of Medical Help	
Trip Description - please tick all appropriate:			
Purpose of Trip:	Business	Pleasure	Other
Type of Trip:	Package	Self organised	Backpacking
	Camping	Cruise Ship	Trekking
Accommodation:	Hotel	Friends/Family	Other
Travelling:	Alone	with Friends/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 (eg. diabetes, heart or lung conditions)			
List all allergies that you have (eg. eggs, nuts, antibiotics)			
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 / No
Does having an injection cause you to feel faint?			Yes / No
Do you or any close family members have epilepsy?			Yes / No
Do you have any history of mental illness including depression or anxiety?			Yes / No
Have you recently undergone radiotherapy, chemotherapy 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
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		Polio	
Diphtheria		Typhoid	
Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever	
Influenza		Rabies	
Jap B Enceph		Tick Borne	
Malaria Tablets		Other	

RETURN TO THE SURGERY BY HAND, POST OR EMAIL trccg.conwayroadmp@nhs.net