



PRE- TRAVEL QUESTIONNAIRE

DOCTORS

To be able to give you the best travel advice we need the information on this form to be as detailed as possible:

Name: _____

D.O.B: _____

Age: _____

Address: _____

E mail: _____

Home Phone: _____

Work Phone: _____

Mobile: _____

Occupation: _____

GP/Medical Practice: _____

Country of Birth: _____

Details of trip

Date of departure: _____

Return Date: _____

What countries, regions, cities do you intend to visit and for how long? (If possible please attach a copy of your itinerary)

What is the purpose of your visit? (Circle and comment as necessary)

Visiting Friends and Family

Business

Holiday

Other

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What type of adventure activities will you be doing on your trip?

Hiking Cycling Scuba Diving Trekking Climbing Other

What type of accommodation will you be using?

Hotel/Motel Family /Friends Backpackers Camping Cruise Other

What type of transport will you be using?

Bus Plane Boat Hire Car Bicycle Motorbike Hitchhiking

Past travel experience

Have you travelled before and if so where to?

Did you have any health concerns on previous travels?

Have you taken antimalarial drugs before?

Vaccination History (please write details below and/or attach a copy of your past vaccination records)

Have you completed your childhood vaccinations? Yes No Unsure

Have you had any travel vaccinations before? Yes No Unsure

If YES- please list them below:

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Medical History and Current Health

1. Do you have or have you ever had (circle):

Heart Disease (i.e. heart attack or angina) Asthma Chronic Lung disease Diabetes Cancer
 Bowel Disease High Blood Pressure Epilepsy Stomach Ulcers Hepatitis/Jaundice Depression
 Other Mental Illness Phobias Migraines Sexually Transmitted Disease Thymus Disorders
 Blood Clot Skin Conditions Eye Disease Arthritis

2. Are you Allergic to Anything? (e.g. medications, vaccines, foods, bees , Sulphur drugs, iodine, eggs, neomycin etc.) Yes no Please list:

3. Have you had a splenectomy? Yes No

4. Do you have a weakened immune system (e.g. HIV, AIDS or other immunological disorders)?
 Yes No

5. Are you on medication now (both regular and occasional and over the counter)? Yes No
 Please list:

6. Have you had any operations or hospital admissions? Yes No

7. Have you been unwell or in hospital over the last 4 weeks? Yes No

8. Are you currently in contact with anyone who has a weakened immune system (e.g. people having chemotherapy, taking steroids, who have AIDs, or are pregnant)? Yes No

Women travellers only

- | | | |
|---|-----|----|
| 1. Are you pregnant or planning to conceive now or within 3 months of your return ? | Yes | No |
| 2. Are you breast feeding? | Yes | No |
| 3. Are you on contraception? | Yes | No |
| 4. Have you ever had a mastectomy? | Yes | No |
| 5. Do you get vaginal thrush? | Yes | No |



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Do you Have Travel Insurance? Yes No

Is there anything you think we should know about that we haven't already asked?

Do you have any particular concerns or questions you would like to ask regarding this trip?

I confirm that the above information is correct.

Signature: _____

Date _____