**\*\*IN ORDER TO ENSURE FULL PROTECTION FOR YOUR TRAVEL THEN THIS FORM MUST BE COMPELTED IN FULL AND RETURNED TO THE PRACTICE AT LEAST 28 DAYS PRIOR TO PLANNED TRAVEL\*\***

**Travel Questionnaire**

**Name**…………………………………………………. **Date of Birth**……………………….… **Age**….…

**Contact telephone number**……………………………………………….

**Date of Trip:**

**Date of Departure:**

**Overall Trip Length**:

**Itinerary:**

Countries to be visited (area if known):

Future Travel plans (if any):

**Purpose of trip**:

Pleasure: **Yes/No**

Work Related: **Yes/No** If Yes, please specify:

If Travel is work related, are you:

Working as a Humanitarian Aid Worker **Yes/No**

Working as a Veterinary Worker **Yes/No**

Working as a Healthcare Worker **Yes/No**

Working in rural or agricultural areas such as rice/marsh fields **Yes/No**

If your travel is work related have you sought advice from the

organising company re foreign travel health advice and immunisation **Yes/No**

**Accommodation:**

Hotel / Hostel / House or home / Camp / Other – Please specify……………………………..

**Further Information**

Are you travelling or likely to be staying in:

1. Areas of poor sanitation / possibility or poor food hygiene Yes / No
2. Remote areas (half days travel to the nearest hospital) Yes / No
3. **Areas / activities where you are at significant risk of being bitten by a wild or domestic animal \* Yes / No**
4. **Areas / activities where you are likely to be exposed to tick bites by prolonged outdoor activities in areas of vegetation \* Yes / No**
5. Could you be engaged in intravenous recreational drug use? Yes / No / Wish to discuss with

Nurse

1. Could you be engaged in casual sexual encounters? Yes / No / Wish to discuss with

Nurse

**\*\*If you have answered yes to either question 3 or 4, you may be at risk of Rabies, Japanese Encephalitis or other private travel vaccines such as Yellow Fever and Cholera. PLEASE SEEK ADVICE FROM A PRIVATE TRAVEL CLINIC. Information is available for local private travel clinics online.\*\***

**Medical Information**

Do you have allergies? Yes / No

Have you recently undergone Radiotherapy, Chemotherapy or Steroid treatment? Yes / No

Do you have any history of mental illness? Yes /No

Do you have any history of epilepsy? Yes / No

Do you have any heart problems? Yes / No

Do you have any kidney problems? Yes / No

Do you have any liver problems? Yes / No

Are you taking any blood thinning medication? Yes / No

Have you had a serious reaction to a vaccine given to you before? Yes / No

Does an injection make you feel faint? Yes / No

**For women only**:

Are you pregnant or planning a pregnancy? Yes / No

Are you breastfeeding? Yes / No

**Travel Insurance**

We strongly recommended that you take out adequate travel insurance and declare all medical conditions to ensure your policy is valid.

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