**Travel Questionnaire**

1. Travel Vaccinations can only be given at our main site in Selby
2. Please ensure we receive this completed form a minimum of 6 weeks prior to your Departure.
3. We will contact you prior to travel. If we are unable to contact you by telephone, we will send you a letter.
4. The letter will inform you whether your current travel requirements are up to date or whether you require vaccination or prescription for malaria prophylaxis, in which case you will be given an appointment.

# **PLEASE NOTE**

1. If you need your Travel Health requirements assessing sooner than this, please attend an independent Travel Clinic (details below).
2. We are no longer able to offer vaccination for Hepatitis B, Rabies, Meningitis, Japanese Encephalitis, cholera, or Yellow Fever.

If you require A or B, please contact an independent Travel Clinic on:

Tel: 0330 I00 4325 Website: [www.masta-travel-health.com](http://www.masta-travel-health.com)

|  |  |  |
| --- | --- | --- |
| **Personal Details** |  |  |
| Name: |  | Date of Birth: |
| Contact Tel No: |  |  |
| Dates of trip: |  |  |
| Date of departure: |  |  |
| Return date: |  |  |
| Overall length of trip: |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Itinerary and Purpose of Trip** | | | | | | | | |
| Country visited including exact location/region | | Length of stay | Away from medical help at destination? | | | | | |
|  | |  |  | | | | | |
| 2. | |  |  | | | | | |
| 3. | |  |  | | | | | |
| Please mark with 'x' as appropriate below to best describe your trip | | | | | | | | |
| 1. Type of trip? | Business Pleasure Other | | | | | | | |
| 2. Holiday type? | Package Self-Organised Backpacking  Camping Cruise Ship Trekking | | | | | | | |
| 3. Accommodation? | Hotel Relatives Other | | | | | | | |
| 4. Traveling? | Alone With family/friend | | |  | In a group | | | |
| 5. Staying in area? | Urban Rural Altitude | | | | | | | |
| 6. Planned activities? | Safari Adventure Other | | | | | | |  |
| **Personal Medical History** | | | | | | | | |
| Do you have any recent or past medical history of note?  Yes No  If yes please detail below (including diabetes, heart disease or lung conditions) | | | | | | | | |
| List any medication you are currently taking | | | | | | | | |
| Do you have any allergies?  Yes | | | | | | | | |
| Have you ever had a serious reaction to a vaccine given to you before? Yes No | | | | | | | | |
| Does having an injection make you feel faint?  Yes | | | | | | | | |
| Do you or any close family members have epilepsy?  Yes | | | | | | | | |
| Do you have any history or mental illness including depression or anxiety? Yes No | | | | | | | | |
| Have you recently undergone radiotherapy, chemotherapy, or  steroid treatment? Yes No | | | | | | | | |
| Are you pregnant, planning pregnancy or breast feeding?  Yes | | | | | |  |  |  |

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