TRAVEL QUESTIONNAIRRE

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 approximately 3 weeks 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

a). If you need your Travel Health requirements assessing sooner than this, please attend an independent Travel Clinic (details below).

b).We are no longer able to offer vaccination for Hepatitis B, Rabies, Meningitis, Japanese Encephalitis or Yellow Fever.

If you require any of the above please contact an independent Travel Clinic (details below).

Contact details Tel:03301004325 Website: www.masta-travel-health.com

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| Personal Details | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | Date of Birth: | | | | | | | | |
| Contact Tel No: | | | | | | | | | Male or Female? Male  Female | | | | | | | | |
| 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? | | | | | | | | |
| 1. | | | | | |  | | |  | | | | | | | | |
| 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. Travelling | | | Alone | |  | | With family/friend | | |  | In a group | | | | |  | |
| 5. Staying in area which is | | | Urban | |  | | Rural | | |  | Altitude | | | | |  | |
| 6. Planned activities | | | Safari | |  | | Adventure | | |  | Other | | | | |  | |
| Personal Medical History | | | | | | | | | | | | | | | | | |
| Do you have any recent or past medical history of note?  If yes please detail below (inc diabetes, heart disease or lung conditions) | | | | | | | | | | | | Yes |  | | No | |  |
| List any medication you are currently taking | | | | | | | | | | | | | | | | | |
| Do you have any allergies? | | | | | | | | | | | | Yes |  | | No | |  |
| 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 |  | | No | |  |
| Do you or any close family members have epilepsy? | | | | | | | | | | | | Yes |  | | No | |  |
| 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 | |  |
| Women only: Are you pregnant, planning pregnancy or breast feeding? | | | | | | | | | | | | Yes |  | | No | |  |
| Have you taken out travel Ins & informed Ins Co of any medical conditions? | | | | | | | | | | | | Yes |  | | No | |  |
| Please write below any further information that you feel may be relevant | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  |  | |  | |  |
| Vaccination History | | | | | | | | | | | | | | | | | |
| Please mark with ‘X’ if you have had any of the following vaccinations/malaria tablets and if so when? | | | | | | | | | | | | | | | | | |
| Tetanus |  | | | Polio | | | |  | | Diphtheria | | | |  | | | |
| Typhoid |  | | | Hepatitis A | | | |  | | Hepatitis B | | | |  | | | |
| Meningitis |  | | | Yellow Fever | | | |  | | Influenza | | | |  | | | |
| Rabies |  | | | Jap B Enceph.. | | | |  | | Tick Borne | | | |  | | | |
| Malaria tabs |  | | | Other | | | |  | | | | | | | | | |

**Signed (Patient):…………………………………………….**

**Dated:……………………………………………..**

|  |  |  |  |
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|  |  |  |  |

**Signed (Clinician):…………………………… Date:………………….**