PRE TRAVEL QUESTIONNAIRE

In order for us to give you the best travel advice, please complete the following questionnaire in as much detail as possible. Please ask if you would like assistance

Name:

Name: DOB: Age:

Your Trip

Departure Date: **Length of Trip:**

What is the main reason for your travel? (Please tick)

- ☐ Holiday
- ☐ Work/Business
- ☐ Visiting friends or family
- ☐ Volunteering
- ☐ For healthcare
- ☐ Study
- ☐ Other -please detail

Who are you travelling with?

- ☐ Solo
- ☐ Partner
- ☐ Family/Friends
- ☐ Group

What style of holiday is it?

- ☐ Independent
- ☐ Organised tour
- ☐ Cruise
- ☐ Backpacking
- ☐ Trekking
- ☐ Camping

What type of accommodation will you be staying in?

- ☐ Hotel
- ☐ Budget
- ☐ Private Home
- ☐ Camping
- ☐ Other

Do you plan any of these activities?

- ☐ Scuba diving
- ☐ High altitude
- ☐ Travel to remote areas
- ☐ Providing medical care
- ☐ Climbing
- ☐ Working with animals
- ☐ Other

How certain are your plans?

- ☐ Very certain
- ☐ Quite certain
- ☐ Uncertain

Have you taken out travel insurance, and have you informed the insurance company of any pre-existing medical conditions, or any plans for adventurous activities?

- ☐ Yes
- ☐ No

Your Itinerary

Please list in order the countries you intend to visit, and how many days you plan to spend in each one:

Country	Main destinations	Rural or urban	Length of stay

Please list any destinations you plan to visit in the future:

Your Health

Question	Yes	No
Have you travelled to developing countries before? If yes, where?	☐ Yes	☐ No
Did you have any health problems while there? If yes, please specify:	☐ Yes	☐ No
Have you ever taken anti-malarial tablets? If yes, which one?	☐ Yes	☐ No
Do you have any specific health concerns or questions regarding this trip? If yes, please specify:	☐ Yes	☐ No
Do you have any concerns about vaccinations? If yes, please specify:	☐ Yes	☐ No
Have you ever felt faint or fainted after an injection?	☐ Yes	☐ No

Do you have, or have you ever had, any of the following medical conditions:

☐ Heart disease	☐ High blood pressure	☐ Diabetes
☐ Blood clot/DVT/PE	☐ Lung condition	☐ Asthma
☐ Prone to chest infections	☐ Cancer	☐ Liver disease/hepatitis
☐ Kidney disease	☐ Epilepsy/Seizures	☐ Stroke
☐ Anxiety/panic attacks	☐ Depression	☐ Other mental illness
☐ Acid reflux/ulcer/ heartburn	☐ HIV/AIDS	☐ Psoriasis
☐ Splenectomy	☐ Joint problems/arthritis	☐ Recent hospitalisation

Question	Yes	No
Do you have any weakness or lowering of your immune system? If yes, please specify:	☐ Yes	☐ No

Do you have any other health problems?

Please list ALL medications you are currently taking or take occasionally:

Question	Yes	No
Do you have any allergies? Please specify:	☐ Yes	☐ No
Do you have a family history of blood clots/DVT or PE?	☐ Yes	☐ No
Women: Could you be pregnant now, or are you planning a pregnancy?	☐ Yes	☐ No
Are you currently breastfeeding?	☐ Yes	☐ No
Are you currently unwell in any way?	☐ Yes	☐ No

Please indicate which statement is the MOST true for you:

- ☐ I would like every available vaccine and/or medication recommended for my destination
- ☐ I will consider all vaccines and medications and decide which ones I would like
- ☐ I only want vaccines that I am legally required to have, for example yellow fever
- ☐ Other (please explain)

Consent to vaccinate - to be signed in the presence of the doctor or nurse:

I consent to receiving the vaccinations as discussed during my consultation. I understand the risks and benefits of the vaccination and have had the chance to ask any questions I may have. I am aware that I may need to remain in the clinic for 20 minutes after the vaccinations.

Signature: **Date:**