HAY-ON-WYE & TALGARTH MEDICAL PRACTICE
TRAVEL HEALTH QUESTIONNAIRE

Please complete this questionnaire and return it to the Medical Centre at least three weeks prior to your Clinic Appointment

TRAVEL IMMUNISATIONS SHOULD BE GIVEN AT LEAST 4 WEEKS BEFORE TRAVEL

NAME: ……………………………………………………… DOB ……………....

ADDRESS: ………………………………………………………………….............

……………………………………………………………………………………

TELEPHONE NUMBER: …………………………………………………………....

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1. Departure date: ____________________ 2. Length of stay: _____________

3. Direct flight : YES/NO

4. Which countries do you intend to visit and the duration in each? Please also state region of country

Please bring any additional paperwork e.g. recommended by travel agents/previous travel vaccination records

5. Will your journey take you to the:
- **Coast** __
- **Inland** __
- **Islands** __

6. Will you be staying in:
- **Tourist Hotels** __
- **Relatives' home** __
- **Local Accommodation** __

7. Are you travelling with:
- **Family** __
- **Partner** __
- **Group** __
- **Alone** __

8. Are you going on:
- **An organized package tour** __
- **Organising it yourself** __
- **Taking a backpacking holiday** __

9. Is your holiday for:
- **Pleasure** __
- **Business** __
- **A period of voluntary service (in a remote area)** __

10. Will you be on safari? YES/NO
If yes please give details: _____________________________________

11. Will you be in areas where medical help is non-existent (even for a short period)? YES/NO
If yes please give details: ____

12. Are you suffering from any minor ailments? YES/NO
If yes please give details: ____

13. Do you have any long term medical conditions? YES/NO
If yes please give details: ____

14. Do you have a history of epilepsy? YES/NO
If yes please give details: ____

15. Do you have any history of depression? YES/NO
If yes please give details: ____

16. Have you ever had your spleen removed: YES/NO

17. Have you ever suffered a bad reaction to any type of vaccine? YES/NO
If yes please give details: ____

18. Do you have any allergies e.g. eggs? YES/NO
If yes please give details: ____

19. Are you currently on any medication including the oral contraceptive pill? YES/NO
If yes pleases give details____

20. Are you pregnant, breast feeding or planning a pregnancy? YES/NO
If yes please give details: ____

22. Have you previously had any vaccinations? YES/NO
If yes please give details:

PREVIOUS VACCINES	DATE

Please note that there are some vaccines required for travel in certain countries which are not provided by the NHS, therefore patients will be charged for these vaccines

DECLARATION BY PATIENT:

I agree that the information I have supplied is correct

Signed: ……………………………………………………….. Date: ……………………

Patient Name: ______________________________ **DOB:** ____________

Patient Number: _____________________

Recommended Date of First Appointment: __________________________

Vaccine Recommended:

Hepatitis A	YES/NO	BCG*	YES/NO
Hepatitis B	YES/NO	YF*	YES/NO
Typhim	YES/NO	Rabies	YES/NO
Tetanus	YES/NO	Meningitis	YES/NO
Polio	YES/NO	Jap B enceph	YES/NO
Diptheria	YES/NO	Tick-bourne e	YES/NO
		Cholera	YES/NO

* Not given at the Medical Centre – if required, you will be re-directed to an appropriate facility

Malaria:

Chloroquine	YES/NO
Paludrine	YES/NO
Mefloquine	YES/NO
Doxycycline	YES/NO
Malarone	YES/NO

Record of Other Advice:

Health advice for travelers leaflet	YES/NO	Food hygiene	YES/NO
Malaria advice and leaflet	YES/NO	Rabies precautions	YES/NO
Sun precautions	YES/NO	Safe Sex	YES/NO
Personal	YES/NO	Accident avoidance	YES/NO
		Travel Insurance	YES/NO

COMMENTS/NOTES:

GP : ....

Nurse : ………………………………………………………….

Date : ………..………………………………………………