**PRE-TRAVEL HEALTH QUESTIONNAIRE**

Please complete the questionnaire as fully as possible prior to your appointment, to help us provide the most accurate and appropriate advice for you.

**Personal details and contact information**

|  |  |
| --- | --- |
| **Name:** | **Your country of origin:** |
| **Date of birth:** | **Male**  **Female** |
| **E-mail:** | **Telephone number:**  **Mobile:** |

**Information about your trip**

|  |  |
| --- | --- |
| **Date of departure:** | **Total length of trip:** |

**Have you taken out insurance for this trip?**

**Do you plan to travel again in the future?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Country to be visited in order of travel**  **(Include any planned transits)** | **Exact location/region (if known)** | **City/Rural** | **Length of stay** |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |
| **4.** |  |  |  |
| **5.** |  |  |  |
| **6.** |  |  |  |

**Type of Travel and Purpose of Trip** (please tick all that apply)

|  |  |  |
| --- | --- | --- |
| * **Holiday** * **Business** * **Volunteer work** * **Healthcare worker** * **Expatriate** * **Medical tourism** * **Pilgrimage** * **Visiting Friends and Family** | * **Resort/Hotel** * **Cruise-ship** * **Camping** * **Backpacking/hostels** * **Staying with friends/family** | * **Adventure** * **Trekking** * **Climbing** * **Diving** * **Safari** |

**Vaccination History** (please supply information on any immunisations or anti-malaria medication you have had in the past)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Date(s)** | **Vaccine** | **Date(s)** | **Vaccine** | **Date(s)** |
| Tetanus/Diphtheria |  | Hepatitis A |  | Rabies |  |
| Polio |  | Typhoid |  | Yellow Fever |  |
| Measles/Mumps/Rubella |  | Cholera |  | Japanese Encephalitis |  |
| Hepatitis B |  | Pneumococcal |  | Meningococcal |  |
| Whooping cough |  | Influenza |  | Tick Borne Encephalitis |  |
| Covid-19  Primary course  Booster |  |  |  |  |  |

|  |  |
| --- | --- |
| Other vaccinations: | Date: |
| Malaria tablets | Date: |

**Medical History** (please supply details of any current of previous conditions)

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you currently or have you had** | **Yes** | **No** | **Details** |
| Any allergies (including to food/latex/medications) |  |  |  |
| Severe reaction to a vaccine |  |  |  |
| Fainting episodes with injections/blood tests |  |  |  |
| Any surgical procedures |  |  |  |
| Recent chemo/radio therapy or organ transplant |  |  |  |
| Bleeding/clotting disorders (including DVTs) |  |  |  |
| Any long-term conditions including diabetes, heart disease, respiratory (lung) problems, epilepsy/seizures or other neurological conditions, liver or kidney problems, HIV/AIDS or other immune system conditions, including spleen problems, rheumatology problems etc) |  |  |  |
| Mental health issues, including anxiety, depression |  |  |  |
| Any other conditions |  |  |  |
| **Women only**  Are you pregnant/breastfeeding/planning pregnancy |  |  |  |

**Medication** (please list details of all prescribed, purchased over-the-counter, and contraceptive medication)

|  |
| --- |
|  |

**Additional Information** (anything you think may be relevant)

|  |
| --- |
|  |

**Once you have submitted the form, please await further contact from our travel health nurse. Your request may be prioritised depending on the departure date given and recommendations advised for your individual trip. If your request is urgent, please call 03 525 0060 to advise our staff of this.**