CLARENCE MEDICAL CENTRE

TRAVEL QUESTIONNAIRE

Name: ______________________ **GP:** ______________

Address: ______________________ **DOB:** ______________

______________________ **Daytime Tel:** ______________

______________________ **Mobile:** ______________

Which countries are you visiting? ______________________

Which area will you visit? ______________________

When do you leave? ______________ **Length of stay:** ______________

Type of travel: Business ☐ Holiday ☐ Touring ☐ Backpacking ☐ Cruise ☐

Accommodation: Hotel ☐ Private Home ☐ Camping ☐ Self Catering ☐

Do you have any medical condition requiring medical care? YES ☐ NO ☐

If yes, please give condition/details: ______________________

Are you pregnant? **YES** ☐ **NO** ☐

Are you taking steroids? **YES** ☐ **NO** ☐

Have you had a reaction to any medicine? **YES** ☐ **NO** ☐

Do you have any allergies? **YES** ☐ **NO** ☐

Any history of epilepsy or depression? **YES** ☐ **NO** ☐

Have you bought travel insurance and informed them of any existing medical condition? **YES** ☐ **NO** ☐

PLEASE GIVE DATES OF IMMUNISATIONS, IF KNOWN:

Tetanus		**Diphtheria**	
Polio		**Typhoid**	
Hepatitis A		**Hepatitis B**	
Yellow Fever		**Meningitis**	

OFFICE USE ONLY:

Vaccine(s) Recommended: ______________________

Start Vacs at least ______________ **weeks before departure date.**

Malaria tablets required? **YES** ☐ **NO** ☐ **Doctor's appointment required?** **YES** ☐ **NO** ☐

Date Patient informed: ______________ **Appointment:** ______________

OFFICE USE ONLY – RECORD OF VACCINES GIVEN

VACCINE	FOR	1st	2nd	3rd	Booster
REVAXIS	Tet / Dip / Polio				
TYPHIM/TYPHERIX	Typhoid				
HAVRIX MONO/AVAXIM	Hepatitis A				
HAVRIX MONO JUNIOR	Hepatitis A				
HEPATYRIX/VIATI	Hepatitis A / Typhoid				
TWINRIX	Hepatitis A / B				
ENGERIX B	Hepatitis B				
STAMARIL	Yellow Fever				
MENINGITIS ACWY	Meningitis ACWY				
RABIES					
AMBRIX	Paediatric Hepatitis A / B				