

# AVIEMORE MEDICAL PRACTICE TRAVEL CLINIC

## Pre-Travel Health Questionnaire

**Before completing this form read instructions at:** [http://www.aviemoremedical.co.uk/travel\\_clinic.htm](http://www.aviemoremedical.co.uk/travel_clinic.htm)  
**Please circle or underline answers as required.** A form to be completed for each person that will be travelling.  
 Where possible, please hand the completed form in at least 8 weeks before your departure.

Surname.....First Name..... Sex M / F      DOB.....  
 Address ..... Daytime Tel No .....  
 email.....Mode of transport: Air /Sea / overland      Date of departure from home.....

**To be filled in by receptionist:** Date form handed in to reception..... Date of appt with nurse.....

1. Please list the countries to be visited with details of your destinations as below including any stopovers. (Stop overs should include short stays in airport terminals) Please fill in as much detail as you can as this helps decide if you need anti-malaria tablets etc. C

Name of country + name of specific destination, if known	Date of arrival in each country	City (Name, if known)	Rural Areas North/south/ East/west/ All over	The Coast North/south east/west	Mountains over 3000 feet (+ dates, if known)	Length of stay in each country

2. Will you at any time be staying more than 24 hours from medical help at the destination?      Yes/No.

3. Where do you intend to stay while abroad?

International Hotel / Budget Hotel / guest house / Camping / with friends or relatives or in family home / other (please give details).....

- 4 What is the purpose of your travel?      Holiday / Business / Other

(i) **Holiday:** package / self organised / back-packing / camping / cruise / trekking / safari / visiting relatives/friends

(ii) **Work:** What type of work? ..... Does it involve close contact with people / animals ?

(iii) **Other:** Please give details: (e.g. Haj, student elective) .....

- 5 Are you travelling: in a group / with family or friends /alone

**6 Are you planning/anticipating doing any sporting activities?** Yes/No

Please give details.....

**7 Have you had any of the following and give details below plus any other medical problems not listed**

Heart Problems / High Blood Pressure / Diabetes /Asthma / Breathing problems / Allergies (eggs, nuts, antibiotics etc) / disorders of the thymus gland / Splenectomy / Severe back problems / Epilepsy / Bleeding disorder / Disorders of blood clotting / Mental illness including depression and anxiety

.....  
 .....

Is there any family history of fits/epilepsy? Yes/No. Please give details.....

Have you had a serious reaction to a vaccine before? Yes/No Please give details.....

Does having an injection make you feel faint? Yes/No

**8 In the past 3 months have you had any of the following ?**

Illness / surgery / dental treatment / radiotherapy / chemotherapy /steroid treatment

Please give details.....

**9 Women only**

Are you pregnant? Yes/No Are you planning to get pregnant? Yes/No

Are you breastfeeding? Yes/No

**10 Do you take any tablets /medication ?** Yes/No (including oral contraceptives or HRT)

Please give details.....

**11 Have you taken out Travel Insurance?** Yes/No

If you have a medical condition, have you told the Insurance Agency about it? Yes/No

**12 Please tick below the vaccinations that you have in the past and the dates**

If you cannot remember the exact date, just put in the nearest month and year or year. Please add any other vaccination details to the list and note those you are unsure about.

Vaccination	✓	Date given	Vaccination	✓	Date given	Vaccination	✓	Date given
Polio			Pneumococcus			Tick borne encephalitis		
Diphtheria			Typhoid			Rabies		
tetanus			HepatitisA			Yellow fever		
BCG			Hepatitis B			Influenza		
Meningitis C/ ACWY			Japanese B encephalitis					

**13. Have you had any of the following tablets for malaria ?**

Chloroquine / proguanil / doxycycline / malarone / Iarium

**Any reaction?** Yes/No Please describe .....