# BILLINGHAY MEDICAL PRACTICE

# TRAVEL QUESTIONNAIrE

**Note**: It is your responsibility to ensure that all vaccinations are completed at least **THREE** months prior to travel. Failure to do so could mean vaccinations do not provide protection and travel insurance is invalid should you become ill. In addition, you may require some vaccinations that are unavailable at the surgery. In those circumstances, you will be advised to attend a travel clinic.

*It is also your responsibility to check that any medications you require while travelling overseas are permitted in that country.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PERSONAL DETAILS** | | | | | |
| Name:  Address: | | | | Date of Birth: | |
| Contact number: | |
|  | | | | | |
| **Dates of Travel** | | | | | |
| Departure Date: Return Date: Duration: | | | | | |
| **Itinerary** | | | | | |
| Country | Location within country | Length of stay | Away from medical help? | | Urban/Rural |
| 1. |  |  |  | |  |
| 2. |  |  |  | |  |
| 3. |  |  |  | |  |
| 4. |  |  |  | |  |
| 5. |  |  |  | |  |
| **Please tick below as appropriate** | | | | | |
| 1.Holiday type: Business/Work ( ) Holiday ( ) | | | | | |
| 2.Holiday Type: Package ( ) Self Organised ( ) Backpacking ( )  Camping ( ) Cruise Ship ( ) Trekking ( ) | | | | | |
| 3.Accommodation: Hotel ( ) Relatives Home ( ) Other ( )  Please specify: | | | | | |
| 4.Planned Activities: Safari( ) Adventure ( ) Other ( )  Please specify: | | | | | |
| **Personal Medical History** | | | | | |
| Do you have recent or past medical history of significance? (inc diabetes , heart, lung conditions etc…) | | | | | |
| List any repeat medication (continue on separate sheet if necessary) | | | | | |
| Do you have any allergies? | | | | | |
| Do you have a history of mental illness or anxiety? | | | | | |
| Have you undergone radiotherapy, chemotherapy or steroid therapy? | | | | | |
| Women only: Are you pregnant or planning to become pregnant? | | | | | |
| Any other relevant information? | | | | | |

I declare that all information given is correct and I give consent for this information to be used as part of a risk assessment.

Signed: Date:

If questionnaire for child under 16 years of age, a parent must complete and sign.

**IMPORTANT NOTE: Failure to give sufficient time prior to travel (THREE MONTHS) may require you to attend a travel clinic for vaccinations. The closest to Billinghay Medical Practice are The Riverside Pharmacy in Sleaford or Boots in Lincoln.**

***OFFICIAL USE ONLY***

**(For Practice Nurse to complete only)**

|  |  |  |
| --- | --- | --- |
| VACCINATION | DATE PREVIOUSLY GIVEN | REQUIRED (Y/N) |
| Tetanus |  |  |
| Polio |  |  |
| Diphtheria |  |  |
| Hepatitis A |  |  |
| Typhoid |  |  |
| Cholera |  |  |
| Other |  |  |
|  |  |  |
| **Malaria Tablets Required?** | | |
| **Official comments:** | | |