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V.A.T. Registration Number 879

Pre Travel Questionnaire

Name ----- DoB -----

Contact Number Home ----- Mobile -----

Date of Departure ----- Date of Return -----

Signature ----- Date -----

I will be visiting the following countries

Length of stay

Type of Accommodation:

Hotel []
 Backpacking []
 Other [] (please state)

I am allergic to the following things:

Eggs No / Yes
 Antibiotics No / Yes
 Other

Medical History

Medication

I have the following:

Psoriasis Yes/No
 Epilepsy Yes/No
 Thymus Disorder Yes/No
 Cardiac Problems Yes/No
 Previous reaction to vaccine Yes/No
 Spleen Removed Yes/No
 Pregnant/possible pregnancy Yes/No
 HIV/Other Yes/No

I take drugs to suppress my immune system
 (Please state which drug(s) below)

Vaccination History

I have had the following vaccinations:

Vaccine	Date
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-----	-----
-----	-----
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Malaria Medication History

I have previously taken:

Paludrine	[]
Chloroquine	[]
Chloroquine/Paludrine	[]
Larium	[]
Doxycycline	[]
Malarone	[]

Please complete and return form to surgery as soon as possible, via fax, email, post or bring to surgery to enable us to give you an appropriate Travel Clinic appointment.

For Surgery Use Only

Nurse Actioned

Patient Informed

Complete

—Scan & Archive