TRAVEL QUESTIONNAIRE

IF YOU ARE PLANNING A FOREIGN HOLIDAY/TRIP PLEASE CALL IN TO THE SURGERY AND COLLECT A TRAVEL QUESTIONNAIRE FORM, OR DOWNLOAD IT FROM THE SURGERY WEBSITE: www.**siltonsurgery**.nhs.uk. YOU SHOULD COMPLETE ONE FORM FOR EACH PATIENT AT THIS SURGERY. RETURN THE FULLY COMPLETED FORM/S TO RECEPTION A **MINIMUM OF 6 WEEKS** (PREFERABLY 8 WEEKS) PRIOR TO TRAVEL. YOU SHOULD THEN TELEPHONE 5 DAYS LATER TO ASCERTAIN IF YOU REQUIRE A **TRAVEL ADVICE** APPOINTMENT WITH A PRACTICE NURSE (20 MINS MINIMUM).

IT IS IMPORTANT TO ANSWER ALL THE QUESTIONS AS FULLY AS POSSIBLE. IF YOU HAVE A TRAVEL VACCINATIONS BOOK SHOW IT TO THE RECEPTIONIST OR ATTACH A PHOTOCOPY TO YOUR COMPLETED QUESTIONNAIRE.

NHS WEBSITE: https://www.nhs.uk/ HAS MORE INFORMATION ON TRAVEL VACCINATIONS INCLUDING WHICH VACCINATIONS ARE PRIVATE (CHARGEABLE)

SOME VACCINATIONS/ MALARIAL TREATMENTS HAVE TO BE GIVEN WITHIN A CERTAIN TIME FRAME AND THE MORE TIME AVAILABLE BEFORE YOU TRAVEL,THE EASIER THE PROCESS WILL BE FOR YOU. Malarial treatments and some travel vaccinations are private so will be chargeable. We do not give Yellow Fever Vaccinations at Silton Surgery.

TRAVEL QUESTIONNAIRE Personal details	
Name:	Date of birth: Male [ ] Female [ ]
Easiest contact number: E mail:	
DATES OF TRIP	
Date of departure:	
Return date or overall length of trip:	

Itinerary and purpose of visit		
Country to be visited	Length of stay	Away from medical help at destination, if so, how remote?
1.		
2.		
3.		

Please **tick** as appropriate below how to best describe your trip						
1. Type of trip	Business		Pleasure		Other	
2. Holiday type	Package		Self organised		Backpacking	
	Camping		Cruise ship		Trekking	
3. Accommodation	Hotel		Relatives/family home		Other	
4. Travelling	Alone		With family/friend		In a group	
5. Staying in area which is	Urban		Rural		Altitude	
6. Planned activities	Safari		Adventure		Other	

PERSONAL MEDICAL HISTORY			
	YES	**NO**	**DETAILS**
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)			
List any current or repeat medications.			
Do you have any allergies for example to eggs, antibiotics, nuts?			
Have you ever had any serious reaction to a vaccine given to you before?			
Does having an injection make you feel faint?			
Do you or any close family members have epilepsy?			
Do you have any history of mental illness including depression or anxiety?			
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?			
Women only : Are you pregnant or planning pregnancy or breast feeding?			
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?			

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Please write below any further information which may be relevant			

ADDITIONAL INFORMATION BOX

PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST					
	Dates		Dates		Dates
Tetanus/polio/diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies		Japanese Encephalitis		Tick Borne Encephalitis	
Yellow Fever		BCG		Other	
Malaria Tablets					

FOR OFFICIAL USE

TRAVEL ADVIVCE AND LEAFLETS GIVEN AS PER TRAVEL PROTCOL					
Food and water and personal hygiene advice		Traveller's diarrhoea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Websites		Travel record supplied			
		Other			

Malaria prevention advice and malaria chemoprophylaxis			
Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further information
e.g. weight of child

Signed by staff member: Position: Date: