Barns Medical Practice

Travel Health Questionnaire

One form to be completed per traveller

Please complete this form as fully as possible and email to: email@medicayr.com

Name:	Date of Birth:
Address:	
Email:	Contact Number:

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW

Date of Departure:		Total Length of Trip:	
Country to be visited	Exact Location	City or Rural	Length of Stay
1.			
2.			
3.			
4.			
5.			

Type of Trip - Please provide details below to best describe your trip

Type of Trip	Package	☐	Self Organised	☐	Backpacking	☐
	Camping	☐	Cruise Ship	☐	Trekking	☐
Reason for Travel	Business	☐	Pleasure	☐	Other	☐
Accommodation	Hotel	☐	Camping	☐	Family/Friends	☐
Travelling	Alone	☐	Family/Friends	☐	Group	☐
Type of Area	Urban Coastal	☐	Rural Inland	☐	Altitude Jungle	☐
Planned Activities	Safari	☐	Adventure	☐	Other	☐

PERSONAL MEDICAL HISTORY

Please list any medication you are currently taking:

Please supply information on any vaccines or malaria tablets taken in the past

Tetanus/Polio/Diptheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies		Japanese Encephalitis		Tick Borne Encephalitis	
Yellow Fever		BCG		Other	

Malaria Tablets		

	Yes	No	Details
Are you allergic to anything? (e.g. eggs, nuts, antibiotics) If so, please specify:	☐	☐	
Have you ever had a reaction to any vaccine or tablets given? If so, please specify:	☐	☐	
Tendency to faint with injection	☐	☐	
Any surgical operations in the past, including e.g spleen or thymus gland removed	☐	☐	
Recent chemotherapy/radiotherapy/organ transplant	☐	☐	
Anaemia	☐	☐	
Bleeding/Clotting disorders (including DVT)	☐	☐	
Heart disease e.g. angina, high blood pressure	☐	☐	
Diabetes	☐	☐	
Disability	☐	☐	
Epilepsy/Seizures	☐	☐	
Gastrointestinal (stomach) complaints	☐	☐	
Liver or kidney problems	☐	☐	
HIV/AIDS	☐	☐	
Immune System condition	☐	☐	
Mental Health issues (including anxiety, depression)	☐	☐	
Neurological(nervous system) illness	☐	☐	
Respiratory (lung) disease	☐	☐	
Rheumatology (joint) conditions	☐	☐	
Spleen problems	☐	☐	
Any other Conditions?			
Women Only: Are you pregnant or breastfeeding?			

Signed: Date:

FOR OFFICE USE ONLY					
Is the patient fit and well today?		**Yes**		**No**	
Name of Vaccine	**Dose**	**Batch Number**		**Site given**	

Vaccine given by:
Doctor's Signature:
Date: