

**Barnabas Medical Centre – Travel Questionnaire**

**Personal Details**

<b>Name</b>	
Date of Birth	
Daytime Tel No	
Email	

**Trip Dates**

Departure date	
Duration of Trip	

**Are you travelling on the same holiday with another member of household also registered with us? If so please only complete one form , and complete additional names below**

Date of Birth	Name

**Details of Destinations**

Country of destination	Duration	Availability of Medical Help
1.		
2.		
3.		
4.		
5.		

**Trip Description – please tick all appropriate boxes**

Purpose of Trip	Business	<input type="checkbox"/>	Pleasure	<input type="checkbox"/>	Other	<input type="checkbox"/>
Type of Trip	Package	<input type="checkbox"/>	Self-organised	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>
	Camping	<input type="checkbox"/>	Cruise Ship	<input type="checkbox"/>	Trekking	<input type="checkbox"/>
Accommodation	Hotel	<input type="checkbox"/>	Friends/Family	<input type="checkbox"/>	Other	<input type="checkbox"/>
Travelling	Alone	<input type="checkbox"/>	With Above	<input type="checkbox"/>	In a group	<input type="checkbox"/>
Location Type	Urban	<input type="checkbox"/>	Rural	<input type="checkbox"/>	Altitude	<input type="checkbox"/>
Activity Type	Safari	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Other	<input type="checkbox"/>

Personal Medical History

List all allergies that you have (e.g. eggs, nuts, antibiotics)

If you have had a serious reaction to a vaccine in the past, which vaccine was it?

Have you recently suffered from any infection (e.g. heavy cold, flu or high temperature?)

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Have you taken out Travel Insurance?

If you have a medical condition, have you told your insurance company about it?

Are you pregnant, planning pregnancy or breast feeding?

Write below any other information that might be relevant

Declaration

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

**Signed:-** ..... **Date:**.....