TRAVEL QUESTIONNAIRE.
LAKESHORE MEDICAL CENTRE 091-841509

PERSONAL DETAILS:

NAME: **……………………………………………………………**
…………………………………………………………
……………………………………………………………
…………………………………………………………….

DATE OF BIRTH:**………………………………………………...**

GENDER : **MALE:** **FEMALE**

CONTACT NUMBER:……………………………………………

DATES OF TRIP:

Date of departure:

Duration of trip:

ITINERARY AND PURPOSE OF VISIT:

	Country to be visited	Length of stay
1		
2		
3		

Please tick as appropriate below to best describe your trip.

1	**Type of trip**	Business		Pleasure		Other	
2	**Holiday Type**	Package		Self-organised		Back-packing	
		Camping		Cruise Ship		Trekking	
3	**Accommodation**	Hotel		Relatives/Family Home		Other	
4	**Travelling**	Alone		Relatives/Family		Group	
5	**Staying in area which is**	Urban		Rural		Altitude	

6	**Planned Activites**	Safari		Adventure		Other	

Personal Medical History

Do you have any past medical history?	YES	NO
List of Current Medications:……………………………………………….. ……………………………………………………………………………….. ……………………………………………………………………………….. ………………………………………………………………………………		
Do you have any allergies, to eggs, antibiotics, nuts? If yes, what are you allergic to?...	YES	NO
Have you ever had a serious reaction to a vaccine given before?	YES	NO
Does having an injection make you feel faint?	YES	NO
Do you or any close family members have epilepsy?	YES	NO
Do you have any recent mental illness, including depression or anxiety?	YES	NO
Have you recently undergone radiotherapy or chemotherapy treatment?	YES	NO
Are you currently pregnant or breast feeding?	YES	NO
Have you taken out travel insurance and if you have a medical condition have you informed the insurance company about this	YES	NO

Please outlined any further information which may be relevant?...
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VACCINATION HISTORY

Have you had the following vaccinations and if so, when?

Tetanus		**Polio**		**Diptheria**	
Typhoid		**Hepatitis A**		**Hepatitis B**	
Meningitis		**Yellow Fever**		**Influenzae**	
Rabies		**Jap B Encephalitis**		**Tick Borne**	

Other Relevant Vaccinations?...
I have no reason to think I may 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…………………….

TRAVEL VACCINATIONS RECOMMENDED FOR THIS TRIP-office use

Hepatitis A	YES	NO	**Meningitis AC WY**	YES	NO
Hepatitis B	YES	NO	**Yellow Fever**	YES	NO

Typhoid	YES	NO	**Rabies**	YES	NO
Cholera	YES	NO	**Jap B encephalitis**	YES	NO
Tetanus	YES	NO	**Anti-malarials**	YES	NO
Diptheria	YES	NO	**Other**	YES	NO

Anti-malarial Choice ………………………..Duration………………………………...

Doctors Signature……………………Date……..