

## BRIERLEY PARK MEDICAL GROUP - TRAVEL QUESTIONNAIRE

Please complete this form and return to reception to book your travel appointment

Name:	Date of Birth:
Address:	Telephone - Home
	Telephone - Mobile
e-mail:	Telephone - Work

**If travelling in under 8 weeks time there is no guarantee of an appointment**

### Please provide information about your trip:

<b>Date of Departure:</b>		<b>Total length of trip:</b>	
Country/Country's to be visited	Exact Location or region	City or Rural	Length of Stay

Accommodation - please tick	Hotel			Camping	
	Backpacking			Other (Please detail)	

Do you plan any safaris, jungle exploration etc.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you recently suffered from any infection e.g. heavy cold/flu/high temperature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant or planning a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking steroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you undergoing radiotherapy/immune suppressants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently having any hospital investigations or treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you or have you ever been treated for Depression or mental healthy issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Current Medication (including prescribed, over the counter, contraceptive pill)

Smoking Status

Never Smoked

Ex-Smoker

Smoker

Date Stopped

New leaf leaflet given

Any allergies - including eggs

Any known drugs or allergic reactions to medications (e.g. Malaria medication) or vaccines

Have you ever had any of the following vaccinations and if so when?

Polio Yes/No Date

Tetanus Yes/No Date

Typhoid Yes/No Date

Hepatitis A Yes/No Date

Hepatitis B Yes/No Date

Yellow Fever Yes/No Date

Anti Malarial Tablets Yes/No If yes which ones - please detail

Signature: .....

Print Name: .....

Date: .....

Appt booked: \_\_\_\_/\_\_\_\_/\_\_\_\_

at: .....am/pm

with: .....

Taken by: .....

Details updated on medical records by:

Date: .....

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