

# Wolstanton Medical Centre

## Pre-Travel Questionnaire

### DETAILS OF TRAVELLER

Name:

Address:

Date of Birth:

### PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW

**1. Which countries are you visiting?**

(exact location or region):

**2. What is your date of departure?**

**3. What is the duration of your stay?**

**4. What type of areas are you visiting?**

(please tick)

Urban

Rural

Both

**5. What type of trip is it?**

(please tick)

Holiday	<input type="checkbox"/>	Staying in a hotel	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>	Additional information
Business trip	<input type="checkbox"/>	Cruise ship trip	<input type="checkbox"/>	Camping/hostels	<input type="checkbox"/>	
Expatriate	<input type="checkbox"/>	Safari	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	
Charity/ Volunteer work	<input type="checkbox"/>	Religious	<input type="checkbox"/>	Diving	<input type="checkbox"/>	
Healthcare worker	<input type="checkbox"/>	Medical tourism	<input type="checkbox"/>	Visiting friends/family	<input type="checkbox"/>	

**6. Who are you travelling with?**

(please tick)

Alone

With family/friends

In a group

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**7. Are you currently taking any medications, including contraception?  
(please tick)**

Yes

No

**8. If yes, please provide details of any medication(s) you are taking, including contraception.**

**9. Do you have any current health conditions?  
(please tick)**

Yes

No

**10. If yes, please provide details of your current health condition(s).**

**11. Are you currently taking a short course of medication such as antibiotics?  
(please tick)**

Yes

No

**12. If yes, please provide details on any short course(s) of medication you are currently taking.**

**13. Do you have any allergies?  
(please tick)**

Yes

No

**14. If yes, please provide detail on any allergies you have.**

## **Wolstanton Medical Centre**

### **Pre-Travel Questionnaire**

**15. Have you ever had a reaction to a vaccine or malaria tablets in the past?  
(please tick)**

Yes

No

**16. If yes, please tell us what vaccine or brand of malaria tablets you had a reaction to (if you remember) and what your reaction was.**

**16. What previous travel vaccinations have you received? Please list any that you can remember having.**

**17. Are you pregnant, planning pregnancy or breastfeeding?  
(please tick)**

Pregnant

Planning pregnancy

Breastfeeding

None of the above

**18. Is there anything else you feel might be relevant?**

Pre-Travel Questionnaire - **To be completed by traveller at least 4 working days prior to appointment and handed in at reception**