PRE-TRAVEL QUESTIONNAIRE

Please complete all questions
Mark appropriate answer with a ✓

For All your Travel Vaccinations & Medical Advise

You

First Name: _____ Surname: _____
Date of Birth: _____ Male ☐ Female ☐ Married ☐ Single ☐
Postal Address: _____ Tel (Home) (____) _____
_____ Tel (Work) (____) _____
_____ Cellular: (____) _____ Fax: _____
Postal Code: _____ E-mail: _____
Occupation: _____ Employer: _____

Your Health

Have you travelled to developing countries before? Yes◯ No◯
Did you have any health problems while away? Yes◯ No◯
Do you have any medical problems? *E.g. Asthma, chronic bronchitis, diabetes, stomach ulcer, psoriasis, splenectomy, epilepsy, high blood pressure, depression, anxiety attacks, mental illness, AIDS, blood clotting disorders, irregular heart beat?* Yes◯ No◯
If yes, please specify: _____
Have you been hospitalized in the last six weeks? Yes◯ No◯
Have you had the disease Hepatitis A (Yellow Jaundice)? Yes◯ No◯
Are you taking any medication now *(e.g. Contraceptive pill, steroids, antibiotics)*? Yes◯ No◯
List all medications? _____
Do you occasionally take medication *(e.g. Migraine tablets, inhalers)* Yes◯ No◯
Are you allergic to anything *(eg eggs, sulpha drugs, penicillin, iodine, bee stings, band aids)*? Yes◯ No◯
If yes, please specify: _____
Have you ever felt faint or fainted after having an injection or giving blood? Yes◯ No◯
Are you in contact with anyone with a weak immune system? Yes◯ No◯
Do you have any particular health concerns regarding this trip? Yes◯ No◯
Please outline _____
Women only: Are you pregnant now, or planning pregnancy, breast feeding? Yes◯ No◯

Your Trip

What is the main purpose of your trip? Holiday☐ Visiting Family/Friends☐ Business☐ Pilgrimage☐ Other ☐
Type of accommodation? Camping☐ Budget☐ Air conditioned hotel☐ Private home☐ Other ☐
Will you be undertaking any adventure activities? Scuba Diving ☐ Mountain Climbing☐ Piloting ☐ Other ☐

DESTINATIONS:

COUNTRY / CITY	DURATION	URBAN	RURAL	DEPARTING	RETURNING
1.				DD / MM / YYYY	DD / MM / YYYY
2.				DD / MM / YYYY	DD / MM / YYYY
3.				DD / MM / YYYY	DD / MM / YYYY

Other

How did you learn of this Travel Doctor?
☐ Been to this Travel Doctor
☐ Newspaper Advert _____
☐ Travel Agent (please name) _____
☐ Doctor (please name) _____
☐ Friend/Relative
☐ Company ☐ Road Sign / Parking Sign
☐ Internet ☐ Telephone Directory

How will you be paying for your visit?
Cash ☐ Credit Card ☐
Cheque ☐ Debit Card ☐

Your signature: _____
Parent or Guardian: _____
Date: _____

OFFSET PRINTERS 031-2079410/1