Travel Questionnaire To be completed by the patient		
Name:	**DOB:**	
Contact Number:	**Date form completed:**	
Destinations	**City/Resort**	**Length of stay (days in each and dates)**
1.		
2.		
3.		
4.		
5.		
6.		
Business or Pleasure Pleas tick	Business □	Pleasure□
Traveling alone or with someone. Please state		
List of activities. e.g. Safari/ Trekking		
Health Questions		
Please state any health problems		
Please list all medications. Include those from your doctor and any you purchase over the counter.		
Please state if you have had any previous reactions to injections or medications.		
Are you pregnant or planning pregnancy?		

This section to be completed by the surgery		
Date form completed:	**By whom:**	
Past Vaccinations		
Date vaccination given	**Vaccination**	**Vaccination Valid until**
Destination	**Vaccinations advised for each destination**	**Vaccinations needed for each destination**
Destination 1		
Destination 2		
Destination 3		
Destination 4		
Destination 5		
Destination 6		
Overall cost of vaccinations		**£**
Patient informed of price?	Yes/No	By whom:
Malaria		
Malaria protocol followed?	Yes/No	By whom:
Patient informed of price?	Yes/No	By whom:
Patient informed how to use tablets?	Yes/No	By whom:

Please pass completed form to administrator to be scanned on to patient record.