

King's College London NHS Health Centre

Pre-Travel Questionnaire

Please provide as detailed answers as possible. All information is treated in strictest confidence.

Personal Details

Name: _____ Date of Birth: _____

Correspondence Address: _____

Telephone no: _____ Email address: _____

Travel Details

Date of departure: _____ Date of return: _____

Destination(s): (please include **all** anticipated destinations)

Accommodation: Camping=C, Hotel=H, Friends/Family=F, Backpacking/Hostels=B, Other=O

| Country | Town/Region | Urban/Rural | Accommodation | Duration |
|------------|-------------|-------------|---------------|----------|
| e.g. Nepal | Lhasa | Rural | C | 5 days |

| Purpose of Travel | Please Tick | Activities | Please Tick |
|--------------------------------|--------------------------|-------------------------|--------------------------|
| Holiday | <input type="checkbox"/> | Trekking/Camping | <input type="checkbox"/> |
| Business | <input type="checkbox"/> | Backpacking/Overlanding | <input type="checkbox"/> |
| Religion | <input type="checkbox"/> | Package holiday | <input type="checkbox"/> |
| Medical elective | <input type="checkbox"/> | Cruise ship | <input type="checkbox"/> |
| Aid work | <input type="checkbox"/> | Climbing/High altitude | <input type="checkbox"/> |
| Visiting friends and/or family | <input type="checkbox"/> | Safari | <input type="checkbox"/> |
| Other (please state): | | Healthcare work | <input type="checkbox"/> |
| | | Sports/Diving | <input type="checkbox"/> |
| | | Other | <input type="checkbox"/> |

Travel Planning (please tick one):

Are you travelling: Alone , with family and/or friend(s) , in a group ?

Have you organised your trip: by yourself , through a travel agent , through a voluntary organisation , through work , or other ? (please state): _____

It is recommended that you read the health advice for the country you are visiting before your appointment with the nurse. Please consult the following link: <http://travelhealthpro.org.uk/countries>

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Medical History

Do you have any medical conditions that may affect your trip? Yes No

If yes, please state: _____

Do you take any regular medication (including inhalers)? Yes No

If yes, please state: _____

Do you have any allergies to:

Medications Yes No If yes, please state: _____

Food Yes No If yes, please state: _____

Eggs Yes No If yes, please state: _____

Other Yes No If yes, please state: _____

Women only

Are you pregnant, planning pregnancy or breast feeding? Yes No

Do you use an oral contraceptive pill? Yes No

If yes, which one: _____

Vaccination History

As far as you are aware, did you receive the normal childhood vaccination schedule in the United Kingdom? Yes No

Have you ever had a reaction to any vaccines/immunisations? Yes No

If yes, please state: _____

Insurance (please tick)

Have you taken out travel health insurance? Yes No

Are there any specific questions relating to you health during travel that you would like answered? (please state)

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Please indicate which of the following vaccinations you have previously received. **Please bring any record of vaccinations to your appointment.**

| Vaccine | Last received (please tick) | | Date received |
|---|-----------------------------|--------------------------|----------------|
| | Full course | Booster | |
| DTP (<i>Diphtheria, Tetanus, Polio</i>) | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| TD (<i>Tetanus, Diphtheria</i>) | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Tetanus alone | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Typhoid | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Meningococcal Group C | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Meningococcal Group A, C, Y, W135 | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Pneumococcal | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Yellow Fever | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Influenza (<i>'flu'</i>) | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Rabies | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| BCG (<i>for tuberculosis</i>) | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| Others (<i>please state</i>): | | | DD / MM / YYYY |
| | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |
| | <input type="checkbox"/> | <input type="checkbox"/> | DD / MM / YYYY |

Please read and sign below the following statement:

I certify that the above answers are true to my knowledge, and that the advice and vaccination recommendations I receive will be influenced by the answers I have provided.

Signature _____ Date _____

Name (*please print*) _____

Thank you.