

TRAVEL QUESTIONNAIRE

DATE FORM SUBMITTED

SURNAME:	
FORENAME:	
ADDRESS:	
DAYTIME TELEPHONE NUMBER:	
DATE OF BIRTH:	
DATE AND DURATION OF TRAVEL:	
DESTINATIONS – PLEASE LIST:	
HOW LONG IN EACH AREA?	
TYPE OF TRIP (Back packer etc)	
ORAL STEROIDS?	
ANY ALLERGIES?	
OVER THE COUNTER MEDICATION	
VACCINATIONS DONE ELSEWHERE (Please bring record card)	
To the best of my knowledge the above is true	
Signed:	Date:

PLEASE TELEPHONE IN 7-10 DAYS FOR RESULTS/ADVICE

Office use only:

Following review of records, you require the following vaccinations:	
Malaria Advice:	
Signature:	Date: