

# CHERITON BISHOP & TEIGN VALLEY PRACTICE

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**CHERITON BISHOP & TEIGN VALLEY PRACTICE**

**TRAVEL QUESTIONNAIRE**

Name: ..... Date of Birth: .....

Sex: Male  Female

Destination(s): .....

Trip Date: .....

Type of Trip:  Package  Backpacking  Trekking

Camping  Cruise Ship  Other

Accommodation:  Hotel  Friends/family  Other

Are you taking STEROIDS?  Yes  No

Are you taking ANTI-CANCER DRUGS?  Yes  No

List all your current medications (including oral contraception): .....

.....  
.....  
.....  
.....

List all allergies that you may have (e.g. nuts, eggs, and antibiotics): .....

.....  
.....  
.....

Are you PREGNANT?  Yes  No

If you have had a serious reaction to a vaccine in the past, which vaccine was it?

.....

Does having an injection cause you to feel faint?  Yes  No

Do you have any history of mental illness including depression or anxiety?  Yes  No

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Yes

No

Please detail any further relevant information: .....

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.....

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.....

If needing MALARIA PROTECTION:

Have you any history of fits?

Yes

No

Have you any history of depression?

Yes

No

### Vaccination History

Have you ever had any of the following vaccinations/tablets and if so, when?

Tetanus  Yes \_\_\_\_\_

Polio  Yes \_\_\_\_\_

Diphtheria  Yes \_\_\_\_\_

Typhoid  Yes \_\_\_\_\_

Hepatitis A  Yes \_\_\_\_\_

Hepatitis B  Yes \_\_\_\_\_

Meningitis  Yes \_\_\_\_\_

Yellow Fever  Yes \_\_\_\_\_

Influenza  Yes \_\_\_\_\_

Rabies  Yes \_\_\_\_\_

Jap B Enceph  Yes \_\_\_\_\_

Tick Borne  Yes \_\_\_\_\_

Malaria Tablets  Yes \_\_\_\_\_

Other  Yes \_\_\_\_\_