Travel Health Questionnaire

When you attend for your travel medical you should bring with you;

- This form
- Any travellers health briefing that you have obtained
- Your vaccination certificates
- Any medication you are taking (or a list of names and dosages)
- Your glasses if you have any

Part A – To be completed by traveller prior to attendance

Surname		First names
Mr / Mrs / Ms / Other	M / F	D.o.B.
Business / Department		Location
Date of next departure and destination (if known)		Contact number
Brief details of likely destinations and frequency of travel during the next 12 months.		

Health questionnaire MEDICAL INFORMATION – CONFIDENTIAL

	Do you have, or have you ever had any of the following?	**YES**	**NO**
1.	Restricted mobility.	☐	☐
2.	Asthma, bronchitis or other lung disease.	☐	☐
3.	Disease of the heart or circulation including angina or high blood pressure.	☐	☐
4.	A pacemaker.	☐	☐
5.	Blood abnormalities such as sickle cell, bleeding problems or use of anticoagulants or aspirin therapy.	☐	☐
6.	A heart attack or *any* surgery/operation within the last 21 days.	☐	☐
7.	Stomach/bowel disorder e.g. stomach or duodenal ulcer, ulcerative colitis, Crohns disease or colostomy.	☐	☐
8.	Problems with motion sickness.	☐	☐
9.	Bladder or urinary problems.	☐	☐
10.	Fits, epilepsy, fainting or blackouts.	☐	☐
11.	Stroke.	☐	☐

12.	Eye conditions such as glaucoma or impairment of vision	☐	☐
13.	Ear or sinus trouble.	☐	☐
14.	Psychiatric illness including depression or anxiety.	☐	☐
15.	Problems with nightmares or insomnia	☐	☐
16.	Diabetes	☐	☐
17.	Eczema, dermatitis, psoriasis or other skin problem.	☐	☐
Female travellers only		**YES**	**NO**
18.	Are you pregnant, planning to become pregnant or breastfeeding?	☐	☐
19.	Are you taking oral contraceptives?	☐	☐
Persons travelling outside Europe, North America, New Zealand, Australia who may require vaccinations or antimalarial medication.		**YES**	**NO**
20.	Have you had a fever in the past 48 hours	☐	☐
21.	Have you ever fainted from having your blood taken?	☐	☐
22.	Have you ever had a reaction, side effect or fever from a vaccination?	☐	☐
23.	Do you or any of your family or close contacts have reduced immunity because of illness, chemotherapy, radiotherapy or immunosuppressive drugs?	☐	☐
24.	Are you allergic to eggs?	☐	☐
25.	Are you allergic to bee stings?	☐	☐
26.	Are you severely allergic to yeast?	☐	☐
27.	Are you allergic to antibiotics such as penicillin, sulphonamide, gentamicin, neomycin, polymixin or streptomycin?	☐	☐
28.	Are you aware of any other allergies?	☐	☐
29.	Are you taking any of the following: Antibiotics. Antidepressants. Aspirin. Chloroquine or mefloquine antimalarials. Steroids e.g. prednisolone or cortisone. Quinine or quinidine for blood pressure.	☐	☐

List any medication that you are taking
If you answered yes to any question please write any comments in this space

Part B – To be completed by Occupational Health Staff

Date	Age	Standard		Version
Questionnaire	Name and version			Result
Habits	Smoking	Alcohol	Medication	
Vision - unaided	R	L	B	N
Vision - aided	R	L	B	N
Height/weight	Ht	Wt		
Cardiac	P	BP	ECG	
Musculoskeletal	Mobility		Flexibility	
Hearing	Conversation			
Urine	Protein	Glucose	pH	
Advice given				

History/exam (continue on history sheets)

Result

Signed Review date

Units Ht = cm, Wt = kg, Blood sugar / cholesterol = mmol/l. Express visual acuity in Snellen notation.