Hope Health Centre,
Hawarden Road,
Hope, Wrexham,
Flintshire. LL12 9NP
Telephone: 01978 760468
Facsimile: 01978 760774
www.wales.nhs.uk/hopefmc
Dr Nicola Wiggs, Dr Heather Pearson, Dr Jo Parry-James, Dr Ruth Pennington, Dr Rosaline Blundell

HOPE FMC TRAVEL CLINIC
Travel Services Questionnaire

Where possible please return this questionnaire & make your initial travel clinic appointment 8 – 12 weeks before departure.

Name:……. Height:……

Address:……. Weight:……...

……...

Daytime Contact No:…….. Date of Birth:……

Are you a registered patient at Hope FMC? YES/NO If not, which Surgery?
……..

Which countries do you intend to visit? Please name actual areas and length of stay (include stopovers):
……..

……..

Will you be staying in hotels or under more primitive conditions (eg camping)?

……..

Are you visiting friends or relatives? YES/NO

Does your journey include Coastal areas? YES/NO &/or Inland areas? YES/NO

Do you plan any safaris, jungle exploration or travel in difficult terrain? YES/NO

(if YES, please give details)……..

Departure date:……Duration of stay abroad:…….

Known allergies:……..

Current Medication:……

(Make sure you plan to take enough supplies to last through your overseas visit)

Have you had or do you suffer from heart disease or any other chronic illness?.....
……..

Please advise us of any other information you feel should be considered for your proposed journey:……

……..

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HOPE FAMILY MEDICAL CENTRE

Questions to be addressed at appointment in travel clinic –

Do you have a fever, diarrhoea or vomiting at present? **YES/NO**

Are you pregnant, planning to become pregnant or breastfeeding? **YES/NO**

Do you have any allergies to foodstuffs or other products eg eggs, gelatine or latex? **YES/NO**

Have you ever tested positive for HIV (Human Immunodeficiency Virus, the AIDS virus)? **YES/NO**

Are you taking steroids or have you taken steroids in the past (prednisolone, cortisone etc or any other drug affecting the immune system)? **YES/NO**

Do you have any other medical condition that may affect your immune system? **YES/NO**

Do you have myasthenia gravis or other thymus disorder e.g. thymoma? **YES/NO**

Have you received treatment for any type of cancer or malignant tumour in the past? **YES/NO**

Will your destination be at high altitude? **YES/NO** Are you taking part in contact sport? **YES/NO**

Vaccine Recommended	Private or NHS	Given/course arranged	Declined	Nurse Initials

Antimalarial recommended	Given/course arranged	Declined	Nurse Initials

I understand the advice given to me in relation to my intended travel. The above information reflects my decision regarding immunisations/antimalarials.

I agree to Hope FMC retaining the above information for record and future reference purposes.

Patient Signature:……**Date:**……..

(Please note any invoice for travel services will need to be paid by cash/ card or cheque either before or on the day of your appointment.)