



TRAVEL MEDICINE QUESTIONNAIRE (TRAVEL CLINIC)

Please complete this form before your appointment and present it to the doctor.

IMPORTANT : Please bring your vaccination card or booklet with you.

Today's date:/...../20....

Your GP:



YOUR JOURNEY

Date of departure :...../...../20...

Return date :...../...../20...

Countries and regions to be visited:

Country 1 : _____ Duration:

Country 2 : _____ Duration:

Country 3 : _____ Duration:

Do you plan to travel often in the future?

Yes | No

Have you ever travelled to tropical countries?

No | Yes (Which ones: _____)

Mode of travel:

Alone | In a group | With family

With a tour operator

Type of holiday:

Tourism / Hotel / Holiday club

Adventure / Backpacking / Homestay

Visiting family or friends

Humanitarian / Professional / Work placement /
Expatriation

Specific activities planned:

Diving

Climbing

High-altitude mountaineering (>2500m)

Trekking



YOUR HEALTH

Do you have any ALLERGIES ?

(Skin rash, swelling, breathing difficulties)

No | Yes :

Eggs | Latex | Vaccines |

Medicines (Please specify: _____)

For women:

Are you pregnant?

Yes | Non

Are you breastfeeding? Yes | No

Are you on the pill? Yes | No

Are you planning to become pregnant within 3
months of your trip? Yes | No

Do you suffer from a chronic or serious illness?

Do you still have your spleen?

Yes | No

Do you have a thymus problem?

Yes | No

Have you ever had an organ transplant?

Yes | No

Do you have HIV / AIDS?

Yes | No

Have you ever had an operation? No | Yes

Yes : _____

Do you suffer from epilepsy, depression, anxiety
or mental health issues?



CURRENT TREATMENTS AND MEDICATION

Are you currently taking medication for:

The stomach? _____

The heart? _____

The lungs? _____

Blood thinners? _____

Psoriasis / Eczema / Rheumatism?

Cortisone or immunosuppressant /
biologic therapy?

Details of your current treatment:

1. _____

2. _____

3. _____

4. _____



YOUR VACCINATION HISTORY & MEDICAL HISTORY

Have you ever had:

Jaundice / Hepatitis A? Yes | No |

Measles? Yes | No

Please state the date of your LAST injection for the following vaccines:

VACCINES	DATE (OR YEAR)	NUMBER OF DOSES RECEIVED (IF KNOWN)
Tetanus / Diphtheria / Polio		
Hepatitis A (Jaundice)		<input type="checkbox"/> 1 dose <input type="checkbox"/> 2 doses <input type="checkbox"/> 3 doses
Hepatitis B		<input type="checkbox"/> 1 dose <input type="checkbox"/> 2 doses <input type="checkbox"/> 3 doses <input type="checkbox"/> 4 doses
Yellow fever		
Typhoid		
Measles / Rubella / Mumps (MMR)		
Meningococcal ACWY		
Rabies		
Japanese Encephalitis		
Tick-borne encephalitis (FSME)		
Covid-19		
Mpox (Monkeypox)		



MEDICAL CHECKLIST (TO BE COMPLETED BY THE DOCTOR)

Section reserved for the exclusive use of the doctor

1. Malaria prophylaxis :

Atovaquone/proguanil

Doxycycline

Mefloquine

No specific measures

2. Vaccines administered today:

STAMARIL

AVAXIM

BOOSTRIX

BOOSTRIX POLIO

POLIO

NIMENRIX

QDENG

TYPHIM

REVAXIS

FSME-IMMUN

FSME-IMMUN JUN

IMOVAX POLIO

IXIARO

IXCHIQ

RABIPUR

VAQTA JUNIOR

ENGERIX

ENGERIX JUN

TWINRIX

TWINRIX JUNIOR

Other : _____

3. Patient information sheets provided & Advice given:

Malaria / PPAV

Diarrhoea / Faecal contamination

Altitude

Rabies / Zoonoses

Travel first-aid kit

Standby treatment

4. Prescription for dysentery / severe diarrhoea:

Azithromycin

Ofloxacin (if allergic to macrolides)

Loperamide