LEITH MOUNT SURGERY TRAVEL FORM

Name : DoB :

Address :

Tel. Home Work

Departure Date :

Duration of Travel :

Type of Travel : Package Hotel Camping
Backpacking
Business
Organised Adventure Tour
Other – please give information

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Destination(s) Please list : ______________________________

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Type of Holiday : Please tick appropriate box

City	Jungle
Beach	Safari
Cruise	Desert
Rural	Diving

Altitude (maximum height expected) ____________

	(Please circle)	
Are you travelling alone?	Yes	No
Are you pregnant or planning to become pregnant?	Yes	No
Are your breast feeding?	Yes	No

Do you suffer from any of the following illnesses : (Please circle)

• Asthma	Y	N
• Epilepsy/Fits	Y	N
• Heart Disease	Y	N
• Bronchitis	Y	N
• Anxiety	Y	N
• Depression	Y	N
• Schizophrenia	Y	N
• Stomach Ulcers/Indigestion	Y	N
• Eczema/Psoriasis	Y	N
• Irritable/Inflammatory Bowel Disease	Y	N
• Do you suffer from any other major illnesses	Y	N
• Clots in the legs or lung (DVT/PE)	Y	N

If so, please give details

Have you had any previous reaction to a vaccine?

Are you allergic to any medicine?

Are you allergic to eggs?

Is your skin type : **Fair** **Medium** **Dark**

Please list all medicines you take :

Prescribed	**Non Prescribed**

Signed ______________________________ **Date** ________________