

# Stainland Road Medical Centre

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[www.stainlandroadmedicalcentre.co.uk](http://www.stainlandroadmedicalcentre.co.uk)



## Pre-Travel Questionnaire (Stainland Road Patients Only)

*Please provide as detailed answers as possible. All information is treated in strictest confidence. This questionnaire allows the nurse to gain as much information as possible prior to your travel appointment so that an appropriate appointment can be given to meet your travel needs.*

### Personal Details

Name:..... Date of Birth:.....  
 Correspondence Address: .....  
 .....  
 Telephone no.: (Work): ..... (Home):.....

### TRAVEL DETAILS

Date of departure:..... Date of return:.....

Any other family members registered at Stainland Road medical Centre on the same trip?

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

Or tick here if you are travelling alone:

### DESTINATION(S): (PLEASE INCLUDE ALL ANTICIPATED DESTINATIONS)

**ACCOMODATION: CAMPING=C. HOTEL=H. FRIENDS/FAMILY=F. BACKPACKING/HOSTELS=B. OTHER=O**

Country	Town/Region	Urban/Rural	Accommodation	Duration
e.g. Nepal	Lhasa	Rural	C	5 days

Purpose of Travel	Please Tick	Activities	Please Tick
Holiday	<input type="checkbox"/>	Backpacking/Camping/	<input type="checkbox"/>
Business	<input type="checkbox"/>	Cruise	<input type="checkbox"/>
Religion	<input type="checkbox"/>	Package holiday	<input type="checkbox"/>
Aid work	<input type="checkbox"/>	Climbing/High altitude	<input type="checkbox"/>
Visiting friends and/or family	<input type="checkbox"/>	Safari	<input type="checkbox"/>
Other (please state):	<input type="checkbox"/>	Healthcare work	<input type="checkbox"/>
	<input type="checkbox"/>	Sports/Diving	<input type="checkbox"/>
	<input type="checkbox"/>	Other	<input type="checkbox"/>

### Medical History

Do you have any medical conditions that may affect your trip? Yes  No

*If yes, please state:* .....  
.....  
.....  
.....  
.....

Do you take any regular medication (including inhalers)? Yes  No

*If yes, please state:* .....  
.....  
.....

Do you have any allergies to:

Medications Yes  No  *If yes, please state:* .....

Food Yes  No  *If yes, please state:*.....

Eggs Yes  No  *If yes, please state:*.....

Other Yes  No  *If yes, please state:*.....

**Women only**

Are you pregnant, planning pregnancy or breast feeding? Yes  No

Do you use an oral contraceptive pill? Yes  No

*If yes, which one:* .....

**Vaccination History**

As far as you are aware, did you receive the normal childhood vaccination schedule in the United Kingdom? Yes  No

Have you ever had a reaction to any vaccines/immunisations? Yes  No

*If yes, please state:* .....

***Please bring any record of vaccinations to your appointment.***

**How to book your travel appointment with the nurse**

Once you have completed this form please return it to reception. A member of the nursing team will use this information to decide how long a travel appointment is needed for you/your family.

**Please can you ring the surgery 1 week after leaving this questionnaire with the receptionist to book for your travel appointment.** The person who you speak to on the telephone will know how long an appointment is needed. This ensures that you are given the right amount of time to cover all the information required for you to have a safe and healthy holiday.

**Payment of all fees is due prior to any treatment being given; non-payment of fees will result in the vaccination/medication not being administered. Payment is by cash or cheque only.**

**Thank you for completing this questionnaire.**

**Official use only**

Date form received:

Date form checked by Nurse: