

YOUR DETAILS

SURNAME:

FIRST NAME:

SEX: MALE FEMALE TITLE: DATE OF BIRTH:

EASIEST CONTACT TELEPHONE NUMBER:

EMAIL:

DATES OF TRIP

Date of Departure: Return date or overall length of trip:

ITINERARY AND PURPOSE OF VISIT

COUNTRY TO BE VISITED/IN TRANSIT	LENGTH OF STAY	AWAY FROM MEDICAL HELP AT DESTINATION, IF SO, HOW REMOTE?
1.
2.
Future travel plans		
1.
2.

PLEASE TICK AS APPROPRIATE BELOW TO BEST DESCRIBE YOUR TRIP

1. Type of trip	Business <input type="radio"/>	Pleasure <input type="radio"/>	Other <input type="radio"/>
2. Holiday type	Package <input type="radio"/>	Self organised <input type="radio"/>	Backpacking <input type="radio"/>
	Camping <input type="radio"/>	Cruise ship <input type="radio"/>	Other <input type="radio"/>
3. Accommodation	Hotel <input type="radio"/>	Relatives/ family home <input type="radio"/>	Other <input type="radio"/>
4. Travelling	Alone <input type="radio"/>	With family/ friend <input type="radio"/>	In a group <input type="radio"/>
5. Staying in area which is...	Urban <input type="radio"/>	Rural <input type="radio"/>	Altitude <input type="radio"/>
6. Planned activities	Safari <input type="radio"/>	Adventure <input type="radio"/>	Other <input type="radio"/>

PERSONAL MEDICAL HISTORY

1. Do you feel well today?	Yes <input type="radio"/>	No <input type="radio"/>
2. Have you had a serious reaction to a vaccine given to you before?	Yes <input type="radio"/>	No <input type="radio"/>
3. Does having an injection make you feel faint?	Yes <input type="radio"/>	No <input type="radio"/>
4. Do you or any close family members have epilepsy?	Yes <input type="radio"/>	No <input type="radio"/>
5. Do you have any history of mental illness including depression or anxiety?	Yes <input type="radio"/>	No <input type="radio"/>
6. Have you recently undergone radiotherapy, chemotherapy, steroid treatment or vaccinations?	Yes <input type="radio"/>	No <input type="radio"/>
7. Are you breastfeeding, pregnant or planning to become pregnant?	Yes <input type="radio"/>	No <input type="radio"/>
8. Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?	Yes <input type="radio"/>	No <input type="radio"/>
9. Do you have any reason to believe that your immunity may be compromised?	Yes <input type="radio"/>	No <input type="radio"/>
10. Have you had any vaccinations in the last 4 weeks?	Yes <input type="radio"/>	No <input type="radio"/>
11. Do you suffer from psoriasis?	Yes <input type="radio"/>	No <input type="radio"/>
12. List any current or repeat medications, including steroids or oral contraceptives. (including over the counter preparations you take)	
11. Do you have any allergies for example to egg, antibiotics or nuts?	

WOMEN ONLY:

12. Please write below any further information which may be relevant.

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VACCINATION HISTORY

Please tick if you have ever had any of the following vaccinations/malaria tablets and if so when and how many times?

Tetanus/Diphtheria/Polio <input type="radio"/>	Date _____	Doses _____	Typhoid <input type="radio"/>	Date _____	Doses _____
Hepatitis A <input type="radio"/>	Date _____	Doses _____	Hepatitis B <input type="radio"/>	Date _____	Doses _____
Meningitis <input type="radio"/>	Date _____	Doses _____	Yellow Fever <input type="radio"/>	Date _____	Doses _____
Influenza <input type="radio"/>	Date _____	Doses _____	Rabies <input type="radio"/>	Date _____	Doses _____
Jap B Enceph <input type="radio"/>	Date _____	Doses _____	Tick Borne <input type="radio"/>	Date _____	Doses _____
Other <input type="radio"/>	Date _____	Doses _____	Malaria Tablets <input type="radio"/>	Date _____	Doses _____

For discussion when risk assessment is performed within your appointment: I have no reason to think that I might be pregnant (if in doubt a pregnancy test may be performed on site). I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed: _____ Date: _____

FOR OFFICIAL USE

PATIENT NAME: _____

	No	Yes	Further information
Travel risk assessment performed:	<input type="radio"/>	<input type="radio"/>	_____
Disease protection	<input type="radio"/>	<input type="radio"/>	_____
Hepatitis A	<input type="radio"/>	<input type="radio"/>	_____
Hepatitis B	<input type="radio"/>	<input type="radio"/>	_____
Typhoid	<input type="radio"/>	<input type="radio"/>	_____
Cholera	<input type="radio"/>	<input type="radio"/>	_____
Tetanus	<input type="radio"/>	<input type="radio"/>	_____
Diphtheria	<input type="radio"/>	<input type="radio"/>	_____
Polio	<input type="radio"/>	<input type="radio"/>	_____
Meningitis ACWY	<input type="radio"/>	<input type="radio"/>	_____
Yellow Fever	<input type="radio"/>	<input type="radio"/>	_____
Rabies	<input type="radio"/>	<input type="radio"/>	_____
Japanese B Encephalitis	<input type="radio"/>	<input type="radio"/>	_____
Other	<input type="radio"/>	<input type="radio"/>	_____

Food water and personal hygiene advice <input type="radio"/>	Traveller's diarrhoea <input type="radio"/>	Hepatitis B and HIV <input type="radio"/>
Insect bite prevention <input type="radio"/>	Animal bites <input type="radio"/>	Accidents <input type="radio"/>
Insurance i.e. Holiday Care <input type="radio"/>	Air Travel <input type="radio"/>	Sun and heat protection <input type="radio"/>
Websites <input type="radio"/>	Travel Record card supplied <input type="radio"/>	Consent forms <input type="radio"/>

MALARIA PREVENTION ADVICE AND MALARIA CHEMOPROPHYLAXIS

Chloroquine and/or Proguanil <input type="radio"/>	Atovaquone and proguanil (Malarone) <input type="radio"/>
Mefloquine <input type="radio"/>	Doxycycline <input type="radio"/>
	Malaria Advice <input type="radio"/>

FURTHER INFORMATION

Signed: _____ Position: _____ Date: _____