Address

Postcode

DOB

Name

F

M

Sex

Best telephone number to contact you on:

Can we leave a message on your voice mail?

Email

Y

N

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Dates of trip** | Start date |  | End date |  |
| **Place you are visiting** |
|  |
| **Please tick as many as appropriate to best describe your trip**  |
| Type of trip  | Business |  | Pleasure |  | Other |  |
| Holiday type | Package |  | Self-organised |  | Backpacking |  |
| Camping |  | Cruise ship |  | Trekking  |  |
| Accommodation | Hotel / Apartment |  | Relatives / Family |  | Other (please state) |  |
| Travelling  | Alone |  | With family/friend |  | In a group |  |
| Staying in an area which is | Urban |  | Rural |  | At altitude |  |
| Planned activities  | Safari |  | Adventure |  | Other |  |
| Personal Medical History |
| Do you have any recent or past medical history of note? (Including diabetes, heart or lung conditions) |
| List any current or repeat medications |
| Do you have any allergies, for example, to nuts, eggs, antibiotics?  |
| Have you ever had a serious reaction to a vaccine given to you before?  |
| Does having an injection cause you to feel faint? | Yes |  | No |  |
| Do you or any close family members have epilepsy? | Yes |  | No |  |
| Do you have any history of mental illness, including anxiety and depression?  | Yes |  | No |  |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | Yes |  | No |  |
| Have you recently suffered from any infection (e.g. heavy cold, flu or high temperature)?  | Yes |  | No |  |
| **Women only:** Are you pregnant or planning pregnancy or breast feeding?  | Yes |  | No |  |
| Have you taken out travel insurance?  | Yes |  | No |  |
| If you have a medical condition, have you told your insurance company about it? | Yes |  | No |  |
| Write below any further information you feel that might be relevant |

|  |
| --- |
| Have you ever had any of the following vaccinations / tablets and if so, when?  |
| Tetanus  | Yes  | Polio  | Yes  |
| Diphtheria  | Yes  | Typhoid  | Yes  |
| Hepatitis A  | Yes  | Hepatitis B  | Yes  |
| Meningitis  | Yes  | Yellow Fever  | Yes  |
| Influenza  | Yes  | Rabies  | Yes  |
| Jap B Encephalitis | Yes  | Tick Borne  | Yes  |
| Malaria Tablets  | Yes  | Other  |

***For discussion when risk assessment is performed with your appointment***:

I have no reason to think that I may be pregnant. I have received information on the risks and benefits of the vaccines recommended and I have had the opportunity to ask questions. I consent to the vaccines being given.

Date

Signed

|  |
| --- |
| For Official Use  |
| Patient’s Name |  |
| Travel risk assessment performed | Yes |  | No |  |
| Travel vaccines recommended for this trip  |
| Disease protection | Yes | No | Provided by the practice  | Further information |
|  |  |  | Yes | No |  |
| Anti-malarial  |  |  |  |  | The practice only provides any anti-malarial medication for ‘one centre’ trips abroad.  |
| Hepatitis A |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |
| Typhoid |  |  |  |  |  |
| Cholera |  |  |  |  |  |
| Tetanus |  |  |  |  |  |
| Diphtheria |  |  |  |  |  |
| Polio |  |  |  |  |  |
| Meningitis ACWY |  |  |  |  |  |
| Yellow Fever |  |  |  |  |  |
| Rabies  |  |  |  |  |  |
| Japanese B encephalitis  |  |  |  |  |  |
| Other |  |  |  |  |  |
| Travel advice and leaflets given as per travel protocol  |
| Food & water | Yes | No | Animal bites | Yes | No | Accidents  | Yes | No |
| Personal hygiene  | Yes | No | Air travel | Yes | No | Sun & heat protection | Yes | No |
| Insect bite prevention | Yes | No | Hepatitis B | Yes | No | Other |  |
| Traveller’s diarrhoea | Yes | No | HIV | Yes | No |

Signed by Date

Position