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