**Abbey Medical Centre**

**Pre-travel Health Questionnaire**

**Name:**…………………………………………………………………………………………………………………...………………...

**Telephone number**:…………………………………………………………………………………………………..………..……

**Date of birth**:…………………………………………………………………………………………………………….……..…….…

**What is your departure date**? …………………………………..……………………………………………...………….....

**How long will you be away**?............................................................................................................

**Which countries will you be visiting**? …………………….………………………………………………..……….…….…

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**Purpose of trip**?...............................................................................................................................

**Type of holiday**? Package tour Organising it yourself Backpacking .………...…….……..…..

**Accommodation**? Hotel Relatives homes Local accommodation ……………..……..….……….

**High risk activities**? E.g. hiring a moped, bungee jumping, scuba diving, white water rafting ……..……………………………………………………………………………………………………………….…………..…………......

**Planned mode of travel**? Public transport Cruise Plane Own vehicle ………..……………….

**Who are you travelling with**?...........................................................................................................

**Will you be staying in**: City Small town Rural village …………………………………………..

**Will you be travelling to remote areas**? (more than 24hours away from medical help)……..……..….

**Do you have a history of epilepsy**?...................................................................................................

**Have you ever experienced anxiety or depression that has required treatment**?............................

**Have you had your spleen removed**?................................................................................................

**Have you ever had a bad reaction to a vaccine**?...............................................................................

**Are you allergic to anything**?.............................................................................................................

**Are you taking any new medication**?................................................................................................

**Are you pregnant or breastfeeding**?..................................................................................................

**Have you recently had treatment with radio/chemotherapy or steroids**?........................................

**Are you HIV positive**?.........................................................................................................................

**OFFICE USE ONLY:**

I authorize the following prescription for the recommended vaccines to be given to the above named patient by Lesia Jeffreys or Brooke Bristow (RGN/PN) in accordance with DOH Green book ‘Immunisation against infectious disease’ and the TRAVAX website/online database for travel health:

 Tetanus, diphtheria, polio

 MMR

 Hepatitis A

 Typhoid

 Hepatitis A/Typhoid combined

 Hepatitis B

 Meningitis ACWY

Meningitis ACWY

Other vaccines required (not given at Practice):

 Yellow fever

 Japanese encephalitis

 Rabies

 Tick borne encephalitis

Malaria:

 Not required for travel to this area

 To be obtained OTC – chloroquine/proguanil

 To be purchase privately @ chemist/travel clinic – malarone/mefloquine/doxycycline

Weight (child malaria dosing):

**Signed by GP**:………………………………………………………………………………………………………………………..