

Personal details

Name:

Date of birth:

Male [] Female []

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

Length of stay

Away from medical help at
Destination? If so, how remote?

1.

2.

Future travel plans

Please tick as appropriate below to best describe your trip

1. Type of trip

Business

Pleasure

Other

2. Holiday type

Package

Self-organised

Backpacking

Camping

Cruise ship

Trekking

3. Accommodation

Hotel

Relatives/family home

Other

4. Travelling

Alone

With family/friend

In a group

5. Staying in area which is

Urban

Rural

Altitude

6. 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 eggs, antibiotics, nuts?

Have you ever had a serious reaction to a vaccine given to you before?

Does having an injection make you feel faint?

Do you or any close family members have epilepsy?

Do you have any history or mental illness including depression or anxiety?

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Are you pregnant or planning pregnancy or breastfeeding?

Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?

Please write below any further information which may be relevant

Vaccination history

Have you ever had any of the following vaccinations / malaria tablets and if so when?

Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
Other					
Malaria Tablets					

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. 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:

Travel risk assessment performed Yes [] No []

Travel vaccines recommended for this trip

Disease protection	Yes	No	Further information
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 and personal hygiene advice		Travellers' diarrhoea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Websites	Travel record supplied				
	Other				

Malaria prevention advice and malaria chemoprophylaxis

Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further information

e.g.

Signed by:.....Position:.....Date:.....