TRAVEL HEALTH QUESTIONNAIRE

SURNAME _____ FIRST NAME_____

D.O.B _____ AGE IF UNDER 16 YEARS _____

ADDRESS _____

_____POSTCODE _____

TEL NO:_____

What, if any, medications do you take? (including contraceptives)

What, if any, allergies do you have?

What, if any, serious illnesses do you have?

All countries and areas to be visited: _____

Departure Date _____ Duration of stay _____

Are you stopping off anywhere? YES ☐ NO ☐

If yes where?

What is the purpose of the trip? Holiday / Business

What type of accommodation will you be staying in?
Hotel/All inclusive Self-catering Camping Friend/relative

Do you plan any of the following: Safaris / Jungle Exploration / Travel in difficult terrain / Coast or Inland areas?
If yes please detail

FEMALES – May you be pregnant or planning a pregnancy? YES ☐ NO ☐

HAVE YOU EVER REACTED BADLY TO ANY PREVIOUS VACCINE ?
YES ☐ NO ☐

IF YES, WHICH VACCINE _____

DO YOU KNOW IF YOU HAVE HAD ANY OF THE FOLLOWING VACCINES AND IF SO, WHEN?

Tetanus			Meningitis ACWY		
Diphtheria			Typhoid		
Polio			Rabies		
BCG (Tuberculosis)			Yellow Fever		
Hepatitis A	1st 2nd		Tick Borne encephalitis		
Hepatitis B	1st 2nd 3rd		Others e.g. MMR		
Japanese B encephalitis			Influenza/Pneumovax		

PATIENT CONSENT

I have received and understood the advice given to me concerning:

☐ Travel vaccination requirements ☐ anti-malarial prophylaxis

☐ General preventative measures ☐ for myself ☐ my child

And consent to the administration of vaccines below.

Signature _____ Date _____

PRACTICE USE ONLY

VACCINATIONS

Recommended	Given	Given By	Patient Specific Direction (PSD)	GP Signature

PAYMENT DUE £_____ N/A ☐

PAYMENT RECEIVED £_____ N/A ☐

ADVICE GIVEN

Mosquito bite avoidance		ANTI MALARIALS	
Avoidance of DVT		Chloroquine	
Malarial advice		Proguanil	
Food and Water advice		Mefloquine	
Sun advice		Malarone	
Personal hygiene / Diarrhoea advice		Doxycycline	