

**Travel Vaccine Questionnaire**

Please complete the form prior at least one month in advance of your travel and submit to reception for review.

**Personal Details:**

|  |  |
| --- | --- |
| **Name:** | **Date of Birth:** |
| **Gender:** |  |
| **Contact No:** |  |

**Date of Trip:**

|  |  |
| --- | --- |
| From: | To: |

|  |
| --- |
| Return Date or overall length of trip: |

**Itinerary & Purpose of visit:**

|  |  |  |
| --- | --- | --- |
| **Countries to be visited** | **Length of Stay?** | **Away from medical help at destination, if so, how remote?** |
| **1.** |  |  |
| **2.** |  |  |
| **3.** |  |  |

**Please tick as appropriate to best describe your trip:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Type of Trip** | **Business** |  | **Pleasure** |  | **Other** |  |
| 1. **Holiday Type** | **Package** |  | **Self-Organised** |  | **Backpacking** |  |
| **Camping** |  | **Cruise Ship** |  | **Trekking** |  |
| 1. **Accommodation** | **Hotel** |  | **Relatives/Family Home** |  | **Other** |  |
| 1. **Travelling** | **Alone** |  | **With Family/Friends** |  | **In a group** |  |
| 1. **Staying in area which is** | **Urban** |  | **Rural** |  | **Altitude** |  |
| 1. **Planned Activities** | **Safari** |  | **Adventure** |  | **Other** |  |

**Personal Medical History:**

|  |
| --- |
| **Do you have any recent or past medical history of note? (including diabetes, heart, lung conditions or epilepsy)** |
| **List any current or repeat medications.** |
| **Do you have any allergies (e.g. eggs, antibiotics, nuts)?** |
| **Have you ever had a serious reaction to vaccines given to you before?** |
| **Do you have any history of mental illness, including depression or anxiety?** |
| **Have you recently undergone radiotherapy, chemotherapy or steroid treatment?** |
| **Women Only: Are you pregnant or planning pregnancy or breast feeding?** |
| **Have you taken out medical insurance and if you have a medical condition, have you informed the insurance company about this?** |
| **Please provide us with any other 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** |  |  |  |  |  |
| **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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Be Completed by Medical Practitioner:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient’s Name:** | | | | |
| **Travel Risk Assessment performed and by whom:** | | | | |
| **Travel Vaccines recommended for this trip:** | | | | |
| **Disease Protection** | **Yes** | **No** | **Patient Declined** | **Further Information** |
| Hepatitis A |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Typhoid |  |  |  |  |
| Cholera |  |  |  |  |
| Tetanus |  |  |  |  |
| Diphtheria |  |  |  |  |
| Polio |  |  |  |  |
| Yellow Fever |  |  |  |  |
| Rabies |  |  |  |  |
| Other |  |  |  |  |

|  |
| --- |
| **Malaria Prevention Advice and Malaria Chemoprophylaxis** |

|  |
| --- |
| **Further Information:** |

**Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GP Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GP Stamp:**

**I consent to the administration of the vaccines recommended above:**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**