TO BE COMPLETED & RETURNED BEFORE BOOKING AN APPOINTMENT

Personal details				
First name:		Date of birth	/ /	
Surname:		Male ☐	Female ☐	
Easiest contact telephone number:				
Email:				

Dates of trip	
Date of departure:	Return date/ length of trip:

Itinerary and purpose of trip		
Country to be visited	Length of stay	Away from medical help at destination, if so, how remote?
1		
2		
Future travel plans:		
Have you taken out travel insurance for this trip? Yes ☐ No ☐		
Do you plan to travel abroad again in the future? Yes ☐ No ☐		

Please circle as appropriate below to the 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	Other
4. Travelling	Alone	With family/friend	In a group
5. Staying in an area which is	Urban	Rural	Altitude
5. Planned activities	Safari	Adventure	Other

Personal medical history		
Are you fit and well today?	Yes ☐ No ☐	Details
Any allergies eg nuts, eggs, latex, medication	Yes ☐ No ☐	Details
Severe reaction to a vaccine before	Yes ☐ No ☐	Details
Tendency to faint with injections?	Yes ☐ No ☐	Details
Any surgical operations in the past, including eg spleen or	Yes ☐ No ☐	Details
thymus gland removed	Yes ☐ No ☐	Details
Recent chemotherapy/ radiotherapy /organ transplant	Yes ☐ No ☐	Details
Anaemia	Yes ☐ No ☐	Details
Bleeding/ clotting disorders (history of DVT)	Yes ☐ No ☐	Details
Heart Disease (e.g angina, high blood pressure)	Yes ☐ No ☐	Details
Diabetes	Yes ☐ No ☐	Details
Disability	Yes ☐ No ☐	Details
Epilepsy/ seizures	Yes ☐ No ☐	Details
Gastrointestinal (stomach complaints)	Yes ☐ No ☐	Details
Liver and or kidney problems	Yes ☐ No ☐	Details
HIV/AIDS	Yes ☐ No ☐	Details
Immune system condition	Yes ☐ No ☐	Details
Mental health issues (eg anxiety/depression)	Yes ☐ No ☐	Details
Neurological (nervous system) illness	Yes ☐ No ☐	Details
Respiratory (lung) disease	Yes ☐ No ☐	Details
Rheumatology (joint) conditions	Yes ☐ No ☐	Details
Spleen problems	Yes ☐ No ☐	Details
Any other conditions?	Yes ☐ No ☐	Details

PLEASE TURN OVER

Women only		
Are you pregnant?	Yes ☐ No ☐	Details
Are you breast feeding?	Yes ☐ No ☐	Details
Are you planning pregnancy while away?	Yes ☐ No ☐	Details

Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?

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
MMR	Other	
Malaria tablets		

PLEASE READ CAREFULLY AND SIGN

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 vaccinations recommended and have had the opportunity to ask questions I consent to the vaccines being given.
I understand that if I require Malaria tablets there will be a £12 fee (per person) to issue & not all vaccinations are covered on the NHS and may require payment.

Signed: _____ Date: _____

FOR OFFICIAL USE

Patient Name:						
Travel risk assessment performed Yes ☐ No ☐						
Travel advice and leaflets given as per travel protocol						
Food water and personal hygiene advice ☐		Travellers' diarrhoea ☐		Hepatitis B and HIV ☐		
		Animal Bites ☐		Accidents ☐		
Insect bite protection ☐		Insurance ☐		Air travel ☐		
Sun and heat protection ☐		Altitude ☐		Other		
Websites				Travel record card supplied Y / N		
Malaria prevention advice and malaria chemoprophylaxis						
Chloroquine and proguanil				Atovaquone + proguanil (Malarone)		
Chloroquine				Mefloquine		
Doxycycline				Malaria advice leaflet given		

Further information

E.g. Weight
of child

Signed: _____
Position: _____
Date: _____

Now scan this form into the patient record on the computer for evidence of best practice