

**TRAVEL QUESTIONNAIRE**

Please complete and return the information requested below in advance of booking an appointment with the GP/Nurse.

It is important to make this initial appointment as early as possible, but we require a minimum of 6 weeks’ notice to provide vaccination. If you are due to travel within the next 6 weeks, we would recommend you contact a travel clinic.

**Cost of Travel Vaccines**

The following travel vaccinations are free to patients and are provided by the surgery:

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| Diphtheria/Tetanus |
| Hepatitis A |
| Polio |
| Tetanus |
| Typhoid |

The following travel vaccinations are not provided by the surgery. If you require any of these vaccinations, you will be directed to a travel clinic.

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| Encephalitis, Japanese |
| Encephalitis, tick borne |
| Hepatitis B |
| Rabies, pre-exposure only |
| Meningitis ACWY |
| Malaria |
| Yellow Fever |

**Please note:**

* It is your responsibility to ensure that you have the recommended vaccines
* Please take into account that only two vaccinations are recommended at any one time



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| **About You** | |
| **Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Contact number (home/mobile):** |  |
| **Any current health problems:**  e.g. Pregnancy, diabetes, heart or lung conditions, epilepsy, thymus disorders, cancer, HIV |  |
| **Are you taking any medication?** | **Yes/No** |
| **Are you pregnant?** | **Yes/No/Not applicable** |
| **Are you planning to get pregnant?** | **Yes/No/Not applicable** |
| **Height:** |  |
| **Weight:** |  |
| **Smoking Status:** | **Never Smoked**  **Ex-smoker**  **Current Smoker of \_\_\_\_\_\_ per day** |
| **Do you have, or have you ever had any of the following:**  Allergies (e.g. Eggs, antibiotics)  A previous reaction to any vaccine  Recent surgery  Treatment with steroids, chemotherapy or radiotherapy  High blood pressure  Epilepsy  Fainting  Anxiety, depression or mental illness |  |
| **Previous vaccinations, if known** |  |



**Present Medication**

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**Previous Immunisations**

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**Allergies**

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| **About your trip** | |
| **What countries are you visiting?**  Give details of the countries you will be visiting. In the correct order, including any country you may be just passing through |  |
| **Date of Departure:** |  |
| **Duration of Stay:** |  |
| **Are you travelling with** | **Family/Group/Alone** |
| **Reason for Travel:** | **Holiday/business/back packing/visiting family and friends** |
| **Type of holiday/travel:** | **Package/self-organised/cruising/camping/trekking/back packing** |
| **Areas to be visited:** | **Urban only/Urban and rural/Rural only** |
| **Planned activities:** | **Leisure/Adventure/Safari** |
| **Type of accommodation:** |  |
| **Travelling to remote areas or away from medical help?** | **Yes/No** |
| **Anything else we need to know about your trip:** |  |

I have received travel information and advice on the risk and benefits of the vaccines recommended and have had the opportunity to ask questions.

I consent to the vaccines being given

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**For Nurses’ use only:**

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| **Needs (no fee)** | **Date last received** | **Required** |
| Diphtheria |  |  |
| Hepatitis A |  |  |
| Polio |  |  |
| Tetanus |  |  |
| Typhoid |  |  |

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| Advised to attend yellow fever clinic? | Yes / No |
| Advised to attend MASTA travel clinic? | Yes / No |

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| **Comments:** |

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| **Practice Nurse’s Signature:** |  |
| **Date:** |  |