

Pre-travel Health and Vaccination Assessment

Personal Details					
Name		Date of Birth:		Age:	
		Male []		Female []	
Telephone contacts: Home		Work		Mobile	
Email address:					
Details of trip:					
Date of departure:			Return date or length of trip:		
Detailed itinerary and purpose of visit					
ALL Countries being visited	Length of stay?	Away from medical help at destination, if so, how remote?			
1.					
2.					
3.					
4.					
5.					
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/friends		In a group
5. Staying in an 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? eg eggs, antibiotics, nuts or latex?					
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 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 breastfeeding?					
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?					
Please add any further information you feel 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 Bourne	
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	Patient declined vaccine	Further information	
Hepatitis A					
Hepatitis B					
Typhoid					
Cholera					
Tetanus					
Diphtheria					
Polio					
Meningitis ACWY					
Yellow Fever					
Rabies					
Japanese B Encephalitis					
Other					
Travel advice and/or leaflets given as protocol					
Food, water and personal hygiene advice		Travellers' diarrhoea		Blood and bodily fluid infection risks eg Hepatitis B	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Websites		Travel record card supplied			
Malaria prevention advice and malaria chemoprophylaxis					
Chloroquine and proguanil		Atovaquone + proguanil			
Chloroquine		Mefloquine			
Doxycycline		Malaria advice given			
Further information					
e.g. weight of child					
Authorisation for Patient Specific Directive (PSD) Use					
Assessor's name: _____		Signature: _____		Date: _____	
Prescriber's name: _____		Signature: _____		Date: _____	