

Pre-Travel Health & Vaccination Assessment

Surname _____

Forename _____

Telephone number _____

Date of Birth _____

Male/Female _____

1. What is your departure date?

2. How long will you be away?

3. Which countries do you intend to visit?
(including brief stopovers)

Note: Only countries mentioned on this form will be discussed at your appointment. If your itinerary changes and you are visiting more countries you will need to submit another form and have a 2nd appointment.

4. Will your journey take you to the:

- coast
- interior
- islands

5. Will you be staying in:

- tourist hotels
- relatives' homes
- local accommodation

6. Are you travelling with

- family
- partner
- alone
- group

7. Are you going on:

- an organised package tour
- organising it yourself
- a backpacking holiday

8. Is your trip for:

- pleasure
- business
- for a period of voluntary service in a remote area
- other _____

9. Will you be going on safari, travelling in areas with poor communication or participating in adventure sports?

Yes No if yes please give details

10. Will you be in areas where medical help is non-existent (even for a short period)?

Yes No if yes please give details

11. Are you suffering from any minor ailments?

Yes No if yes please give details

12. Do you have any long-term medical conditions?

Yes No if yes please give details

13. Do you have a history of epilepsy?

Yes No if yes please give details

14. Have you ever experienced anxiety, depression or other psychological problems which required treatment?

Yes No if yes please give details

15. Have you had your spleen removed?

Yes No if yes please give details

16. Have you ever had a bad reaction to a vaccine?

Yes No if yes please give details

17. Do you have any other allergies, e.g. eggs?

Yes No if yes please give details

18. Are you taking any medication including the oral contraceptive pill, or have you been on antibiotics within the last 10 days?

Yes No if yes please give details

19. Are you pregnant, breast-feeding or planning pregnancy?

Yes No if yes please give details

20. Are you HIV positive?

Yes No if yes please give details

21. Have you recently received treatment with radiotherapy, chemotherapy or steroids?

Yes No if yes please give details

22. Are any children who are travelling up to date with their childhood vaccinations?

Yes No if no please give details

23. Have you had any of these vaccinations in the last 3 weeks?

Yellow fever BCG
MMR

24. Have you had any of the following vaccinations and, if so, when?

Typhoid Meningitis
Tetanus Rabies
Polio Hepatitis A
Yellow Fever Hepatitis B
Japanese Encephalitis Diptheria
Tick-borne Encephalitis
Other _____

Signature _____

Date _____