Travel Health and Vaccination Assessment

Surname:	**Forename:**	
DOB:	**Tel:**	
Smoker/Non-Smoker (please delete as appropriate)		

1. Departure Date:

2. Length of Stay:

Destination: (include stopovers, even if short stays in airport terminals)

Date of Departure	Country	Cities	Rural Areas	The Coast	Length of Stay
		Yes/No	Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No	Yes/No

3. How are you travelling to your destination? Please circle all that apply
Aeroplane Boat Car Train Bus

4. How are you staying? Please circle all that apply
Hotels Relatives Home Local Accommodation Camping

5. Who are you travelling with? Please circle all that apply
Family Partner Alone Group

6. How has it been arranged? Please circle all that apply
Organised Package Tour Self-organised tour Backpacking Safari

7. Why are you going? Please circle all that apply
Business Pleasure Voluntary services involving periods in remote areas

8. Will you be travelling in areas with poor communication? Yes/No

9. Will you be participating in adventure sports? Yes/No

10. Will you be in areas where medical help is non-existent? Yes/No

11. Do you have any long-term medical conditions? Yes/No
If Yes, please give details:

12. Do you have a history of epilepsy? Yes/No

13. Have you ever experienced anxiety, depression or other psychological problems which have required treatment? Yes/No
If Yes, please give details:

14. Have you had your spleen removed? Yes/No

15. Do you have any allergies? E.g.Eggs? Yes/No
If Yes, please give details:

16. 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:

17. Women Only: Are you pregnant?
Do you think you may be pregnant?
Are you breast feeding?
Planning a pregnancy?

18. Please tick the following vaccinations that you have been given in the past and the dates that you had them. If you do not know the exact date, just put in the nearest month/year. Please add any other vaccination details to the list and note those you are

Vaccination	Date	Vaccination	Date	Vaccination	Date
Polio		Typhoid		Yellow Fever	
Hepatitis A		Diptheria		Hepatitis B	
BCG		Tetanus		Rabies	
Tick Borne Encephalitis		Japanese B Encephalitis		Meningitis ACWY	

Any others?

Thank-you for completing this form. Please make sure you hand this form to reception and make an appointment for travel health advice as soon as possible. The Nurse will contact you if you do NOT need the appointment.

For Office Use Only: Please allow at least one week before booking appt to allow for original notes to be retrieved.

Appointment Date & Time	
Please Circle which Nurse	**Nurse WM/LW/KR**
Staff Initials:	