Elliott Street Surgery	Travel Questionnaire
Name:	**Sex: M / F**
Date of Birth:	**Postcode:**
Home Telephone number:	**Mobile phone number:**
Email:	
Departure Date:	**Return Date or Length of Trip:**

Country to be visited:	Duration of stay	Away from medical help at destination? If so how remote?
1		
2		
3		
4		
Future Travel Plans:		

Trip Description – please tick all appropriate boxes:						
Purpose of Trip	**Business**		**Pleasure**		**Other**	
Holiday Type	**Package**		**Self-Organised**		**Back-packing**	
	Camping		**Cruise Ship**		**Trekking**	
Accommodation	**Hotel**		**Family/Friends home**		**Other, please specify**	
Travelling	**Alone**		**With family/friends**		**In a group**	
Location Type	**Urban (town/city)**		**Rural (countryside)**		**Altitude**	
Planned Activities	**Safari**		**Adventure**		**Other**	

Personal Medical History
List any past or recent medical conditions that you have (e.g. Diabetes, heart or lung conditions)
List any current or repeat medication including oral contraception (please attach copy of tear-off slip of repeat prescription or attach separate sheet of paper)
List any allergies that you have (e.g. Eggs, nuts, antibiotics) (please attach separate sheet of paper if necessary)
If you have had a serious reaction to a vaccine in the past which vaccine was it?
Does having an injection cause you to feel faint?
Do you or any close family members have epilepsy?
Do you have any history of mental illness, depression or anxiety?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
Have you recently suffered from any infections (e.g. heavy cold, high temperature)?
Women only: Are you pregnant, planning pregnancy or breastfeeding?
Have you taken out travel insurance and informed them of any medical condition?
Any further information which maybe 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 Borne	
Other					
Malaria Tablets					

Anything for discussion when risk assessment is performed within your appointment?

Declaration: 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.

Patient's signature: ---------- **Date:** ----------

FOR OFFICIAL USE			
Patient Name:			
Travel risk assessment performed: **YES** **NO**			
Travel Vaccines recommended for this trip			
Disease Protection	**YES**	**NO**	**Further Information**
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis AGWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

Travel advice and leaflets given as per travel protocol					
Food, water and personal hygiene advice		Travellers' diarrhoea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air Travel		Sun & Heat protection	
Websites		Travel record supplies		Other	

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 by : ---------- **Position:** ---------- **Date:** ----------