TRAVEL VACCINATION QUESTIONNAIRE

Please complete this form and return it to the receptionist.
The Practice Nurse will contact you by phone to discuss your holiday requirements at an agreed date and time.

Please use the space provided if you need to provide any further information.

NAME	***DATE OF BIRTH***
ADDRESS	***TEL***
DESTINATIONS – COUNTRY AND RESORT (Include any stopovers on the journey)	
REASON FOR TRAVEL *Pleasure / Business*	***LENGTH OF STAY***
DATE OF TRAVEL	***TYPE OF ACCOMODATION*** (e.g. hotel, self catering, camping, backpacking, etc)
*PLEASE LIST ANY **ALLERGIES***	PLEASE LIST ALL **REGULAR MEDICATION**
Are you **pregnant** or might you be before you travel? Yes / No	

PREVIOUS INJECTIONS (Ask for help if you need it. State if you have had any previous adverse reactions)

INJECTION	Yes / No	Date	INJECTION	Yes / No	Date
Tetanus			Hepatitis A		
Polio			Hepatitis B		
Rabies			Cholera		
Yellow fever			Meningitis A/C		
Tuberculosis			Malaria		
Typhoid					

Have you had a blood test for Hepatitis A or B? Yes / No	
Have you had a serious reaction to a previous vaccine? Yes/No	If yes, please provide details of vaccine and reaction:
Does having an injection cause you to feel faint? Do you have any history of mental illness including depression or anxiety? Have you recently undergone radiotheraphy, chemotheraphy or steroid treatment? Have you taken out travel insurance? If you have a medical condition, have you told your insurance company about it?	Yes/No Yes/No Yes/No Yes/No Yes/No
Patient signature ……..	Date
I consent to information relating to this travel to be discussed with (eg spouse, partner, family member) …… Name …… Patient signature ……	

Please add any additional information below: