MARFLEET GROUP PRACTICE

TRAVEL VACCINATION QUESTIONNAIRE

Please complete page 1 and 2 of this form and return to reception. This will be completed by the nurse within 10 working days. Please collect completed form from reception

Personal Details	
Name:	Date of Birth: Male [ ] Female [ ]
Contact Phone number	
E mail	
Dates of Trip	
Date of Departure	
Return date or overall length of trip	

Itinerary and purpose of visit		
Country to be visited	Length of stay	Away from medical help at destination, if so, how remote?
1.		
2.		
3.		

Please tick as appropriate below to best describe your trip						
1.Type of trip	Business		Pleasure		Other(please specify)	
2. Holiday Type	Package		Self-organised		Backpacking	
	Camping		Cruise ship		Trekking	
3. Accommodation	Hotel		Relatives/family home		Other(please specify)	
4. Travelling	Alone		With family/friend		In a group	
5. Area in which staying	Urban		Rural		Altitude	
6. Planned activities	Safari		Adventure		Other(please specify)	

Personal Medical History
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions or Spleen removal)
Please list any repeat or acute medications
Do you have any allergies to eggs, antibiotics, nuts?
Have you ever had a serious reaction to a vaccine given to you before?
Do you or any close family member 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 breast feeding?
Have you taken out travel insurance? If you have a medical condition have you informed the insurance company about this?
Please write below any further information which may be relevant

Vaccination History including Child hood and School Vaccinations					
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					

For discussion when risk assessment is performed should you need an appointment

I have no reason to think 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…………………………………………………………

<table>
<tr><td colspan="6" align="center">For Official Use</td></tr>
<tr><td colspan="6">Patient Name</td></tr>
<tr><td colspan="6">Travel risk assessment performed Yes [ ] No [ ]</td></tr>
<tr><td colspan="6" align="center">TRAVEL VACCINES RECOMMENDED FOR THIS TRIP</td></tr>
<tr><td>Disease Protection</td><td>Yes</td><td colspan="2">No</td><td colspan="2">Further Information</td></tr>
<tr><td>Hepatitis A</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Hepatitis B</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Typhoid</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Cholera</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Diphtheria</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Polio</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Meningitis ACWY</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Yellow Fever</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Rabies</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Japanese B Encephalitis</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Other</td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="6" align="center">Travel advice and leaflets given as per travel protocol</td></tr>
<tr><td>Food, water and personal hygiene</td><td></td><td>Traveller’s diahhoea</td><td></td><td>Blood and bodily fluid infection risks e.g Hep B</td><td></td></tr>
<tr><td>Insect bite prevention</td><td></td><td>Animal bites</td><td></td><td>Accidents</td><td></td></tr>
<tr><td>Insurance</td><td></td><td>Air travel</td><td></td><td>Insect bites</td><td></td></tr>
</table>

Websites		Other			

MALARIA PREVENTION ADVICE and MALARIA CHEMOPROPHYLAXIS			
Chloroquine and proguanil		Atovaquone and proguanil	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice given	

FURTHER INFORMATION

e.g weight of child

Authorisation for patient specific direction (PSD) Use

Name………………………………………………………………………………

Signature…………………………………………..Date