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| --- |
| Please book an appointment with a nurse upon collecting this form. Our nurse can then cancel your appointment if your vaccines are all up-to-date and you do not need travel advice, or if we are unable to supply the vaccines you need.  Please complete this form 6-8 weeks before travel, and please hand it on prior to your appointment.  **We are ONLY doing NHS funded vaccines, you will need to attend a private clinic for non-NHS vaccines: Rabies, Hepatitis B, Tick, Japanese encephalitis, Meningitis and Yellow fever [please see surgery travel leaflet for alternative centres.** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | | | | | | |  | | | | | | | | | | | | | Age: | | | | |  | |
| Date of Birth: | | | | | | | | | |  | | | | | | | | | | | | | Gender: | | | | |  | |
| Telephone Number: | | | | | | | | | |  | | | | | | | | | | | | |
| If for any reason we are unable to contact you, can we leave a message with a relative? YES/NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, who and which number is best: | | | | | | | | | | | | | | Name: | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | Number: | | | | | |  | | | | | | | | | |
| Trip dates: | | | Departure: | | | | | | | | | | | | | | | Return: | | | | | | | | | | | |
| Length of Trip: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Purpose of visit: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Itinerary: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Country/Place: | | | | | | | | | | | | | Length of stay: [in each country] | | | | | | | | | | | | | | | | |
| 1 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you staying somewhere remote, away from medical help? | | | | | | | | | | | | | | | | | | | | | | | YES | | | | NO | |
| If yes, where? | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have any recent or past medical history that could affect the choice of vaccines or malaria tablets? If yes, please write below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you on any repeat medication supplied by a private clinic, hospital, or chemist? If yes, please write these here: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have any allergies? E.g.: Eggs, Antibiotics, medicines, plasters, etc? | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Trip Description: | | | | | | PLEASE CIRCLE YOUR ANSWERS BELOW. | | | | | | | | | | | | | | | | | | | | | | | |
| Trip Type: | | | | Business | | | | | | | Leisure | | | | | | | | | | Other | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Holiday Type: | | | | Package | | | | | | | Self-organised | | | | | | | | | | Volunteer | | | | | | | | |
|  | | | | Backpacking | | | | | | | Camping/Glamping | | | | | | | | | | Cruising | | | | | | | | |
|  | | | | Trekking | | | | | | | Medical/Surgery | | | | | | | | | | Other | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accommodation: | | | | | | | | Hotel | | | | | | | | | Hostel | | | | | | | Cruise ship | | | | | |
|  | | | | | | | | Tent | | | | | | | | | Apartment | | | | | | | Family home | | | | | |
|  | | | | | | | | Other | | | | | | | | |  | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Travelling: | | | | | | | | Alone | | | | | | | | | Family/Friends | | | | | | | Group | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Area: | | | | | | | | Urban | | | | | | | | | Rural | | | | | | | High Altitude | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Planned Activities: | | | | | | | | Safari | | | | | | | | | Adventure | | | | | | | Scuba-diving | | | | | |
|  | | | | | | | | Helping Animals | | | | | | | | | Other | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever had a serious reaction to a vaccine given to you before?  E.g.: Anaphylaxis, breathless, chest pain. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have any of the following conditions, if so please circle them: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Thymus disorder/ Removal | | Spleen disorder/ Removal | | | | | | | Kidney or liver problem | | | Heart disease/ Surgery | | | | | | | HIV | | | Diabetes | | | Previous DVT/ Clots | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | YES | | | NO | | |
| Does having an injection make you feel faint? | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
| Do you or any family members have epilepsy/fits? | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
| Do you have any history of mental illness inc. depression/anxiety? | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
| Have you recently undergone radiotherapy, chemotherapy, or steroid treatment? | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
| Have you taken out travel insurance? If you have any medical conditions, have you informed the insurance company about this? | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
| Females Only: Are you pregnant, planning pregnancy or breast feeding? | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
| Please give any further information that may be relevant including any future travel plans in the next 6 months. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you had any vaccinations outside the surgery e.g., private clinics/MOD? If so, when and what were they? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I give permission for the nurse to check my notes prior to my appointment and ring me or my nominated person for further information if needed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | | | Signed on behalf of patient | | | | | | | | | | | | |
| Signature: | | | | | | | | | | | | | | | | Date: | | | | | | | | | | | | |