SYCAMORE HOUSE SURGERY TRAVEL QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire, which is designed to ensure you receive best advice for safe travel. In order to provide this service to you, we ideally require **4/6 weeks** notice of your travel plans (in order for the vaccinations to work, they need to be given **at least 4** weeks pre travel).

Personal details		
Name:	Date of birth: Male [ ] Female [ ]	Age:
Telephone numbers: Home:	Work:	Mobile:
E mail		

Dates of trip	
Date of Departure:	Date of return:
Overall length of trip in days:	

Itinerary and purpose of visit		
Country to be visited	Region (eg Amazon Basin)	Length of Stay (in days)
1.		
2.		
3.		
4.		
5.		
6.		

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

Personal medical history

If you are newly registered please include any past medical history of note (including diabetes, heart or lung conditions or HIV, etc. Cancer)

List any current or repeat medications:

Do you have any allergies for example to eggs, antibiotics, nuts?

Have you ever had a serious reaction to a vaccine given to you before?

Does having an injection make you feel faint?

Do you or any close family members have epilepsy?

Do you have any history or mental illness including depression or anxiety?

Have you recently undergone radiotherapy, chemotherapy or steroid treatment or immuno-supresive therapy ?
eg. Methotrexate, Sulphasalazine, Azathiaprine

Women only: Are you pregnant or planning pregnancy or breast feeding?

Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?

Please write below any further information which may be 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 / Side effects					

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.

Signed: Parent / Guardian for child. Date:

FOR OFFICIAL USE			
Patient Name :			
Travel risk assessment performed	Yes [ ]	No [ ]	Nurse Name:

Travel vaccines recommended for this trip			
Disease protection	Recommended **Y / N**	**Patient declined vaccine**	**Further information**
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other ? Any drug interactions			

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 and heat protection	
Websites		Travel advice & record card supplied			
		Other			

Malaria prevention advice and malaria chemoprophylaxis					
Chloroquine and proguanil	OTC		Atovaquone + proguanil (Malarone)	Prescription	
Chloroquine	OTC		Mefloquine	Prescription	
Doxycycline	Prescription		Malaria advice leaflet given		

Further information
eg. Weight of child
Assessor's Name:_____ **Signature:** _____ **Date:** _____
Prescriber's Name:_____ **Signature:** _____ **Date:** _____