**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 **6/8 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: Age:<br>Male [ ] Female [ ] |
| 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)<br><br>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 ?<br>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:** _________________