HANDFORTH HEALTH CENTRE : PRE-TRAVEL QUESTIONNAIRE

Personal Details	
Name:	Date of birth: Male ☐ Female ☐
Easiest contact telephone 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.		
Future Travel Plans		

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
Do you have any recent or past medical history of note (including diabetes, heart or lung conditions)?
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 of mental illness, including depression or anxiety?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
Women only: Are you pregnant, planning pregnancy or breastfeeding?
Have you taken out travel insurance and if you have a medical condition informed the insurance company?
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					

For discussion when risk assessment if performed within your appointment:

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: _____ Date: _____

FOR OFFICIAL USE

Patient Name:

Travel risk assessment performed? Yes ☐ No ☐

Travel vaccines recommended for this trip

Disease protection	Yes	No	Further Information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis AGWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

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 record supplied			
		Other			

Malaria prevention advice and malaria chemoprophylaxis

Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further information

eg weight of child

Signed by: _____ Position: _____ Date: _____