

THE GREEN HOUSE SURGERY

PRE TRAVEL HEALTH & VACCINATION ASSESSMENT

Please answer **ALL** questions and return the questionnaire to the Surgery as soon as possible, ideally **12 weeks BEFORE** you travel

Surname	
First Name	
DOB:	
Address:	
Day Time Telephone	
Evening telephone	
Mobile	

TRAVEL DETAILS

Date of departure	Country List all	City or Area List all	Rural areas? Y/N	Length of stay

Please attach further details if there is not enough space to list all areas to be visited.

Tick any boxes that relate to your trip

Tourist Hotel	<input type="checkbox"/>	Package Tour	<input type="checkbox"/>	Pleasure	<input type="checkbox"/>
Cruising	<input type="checkbox"/>	Self organised	<input type="checkbox"/>	Business	<input type="checkbox"/>
Relatives	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>	Voluntary Services	<input type="checkbox"/>
Self- catering	<input type="checkbox"/>	Camping	<input type="checkbox"/>	Remote areas	<input type="checkbox"/>

The travel health nurse will use this information to give you the required advice and recommend vaccines for your trip. You will be invited to make a Travel Health Appointment in good time prior to your trip. You will be contacted by Letter or Telephone.

IF YOU HAVE HAD VACCINES IN THE PAST – please attach your record card or a photocopy if possible

Please complete the questions on the reverse of this form

MEDICAL DETAILS

Diabetes		Heart Problems		Depression	
Asthma		Liver Problems		Mental Illness	
Epilepsy		Fits or Convulsions		Any other Chronic Health Problems	
Allergies		Give details		Have you had your spleen removed	

Have you ever had a bad reaction to a vaccine Yes No

Please list any medication recent hospital treatment, chemotherapy radiotherapy or steroids		

Ladies Only

Are you pregnant?	Yes/No
Are you taking the contraceptive pill?	Yes/No
Are you planning a pregnancy?	Yes/No
Are you taking HRT?	Yes/No

OFFICE USE ONLY

Comments	Vaccines Recommended	Comments	Vaccines Recommended

Malaria Prophylaxis	Yes	Product recommended
	No	

I consent to the recommended vaccines which have been explained to me:

Patient signature _____ **Date** _____

Parent/Guardian _____