Receptionist.....

Date.....

ST JOHNS TRAVEL HEALTH QUESTIONNAIRE

Dear Traveller

In order to advise you on appropriate vaccinations, please ensure that you fill out all sections of this questionnaire to avoid any delays in receiving your holiday and travel advice. After filling out this form please return it to the surgery and phone us 7 days after (please phone after 1.30pm) to see what vaccinations you require and to make an appointment with the Nurse. **If you are travelling at short notice please inform Reception**.

Name..... Date of birth.....

Address.....

Telephone No..... Mobile No.....

Date of Departure.....

Return date of overall length of trip.....

Countries	**Cities**	**Resorts**
Please include length of travel stay and any stop overs		

Please tick as appropriate below to best describe your trip						
Type of trip	Business		Pleasure		Other	
Holiday type	Package		Self Organised		Backpacking	
	Camping		Cruise Ship		Trekking	
Accommodation	Hotel		Relatives / family home		Other	
Travelling	Alone		With family / friend		In a group	
Staying in area which is	Urban		Rural		Altitude	
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 etc?
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?
Women only: Are you pregnant or planning pregnancy or breastfeeding?
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

Have you had the following vaccinations?

Vaccination	Please tick & date if known	Recommended - (Nurse to fill in)
Tetanus		
Polio		
Typhoid		
Hepatitis A		
Hepatitis B		
Rabies		
Yellow Fever		
Pneumococcal		
Combined Diphtheria/Tetanus		
Low dose diphtheria		
Combined Typhoid/Hep A		
Combined Hep A & B		
Meningococcal A & C		
Influenza (flu)		
Tick-borne encephalitis		
Japanese B encephalitis		
Measles, Mumps, Rubella		

Advice has been given regarding: (to be filled in by Nurse)

- Animal bites
- Food/water (diarrhoea management)
- Care re sexual behaviour
- Sun & heat protection
- Insurance
- Mosquito bite protection

Malaria medication

- 1 Chloroquine & Proguanil
- 2 Chloroquine
- 3 Mefloquine
- 4 Doxycycline
- 5 Malarone
- 6 Weight of child.....
- 7 Other

Malaria management

- 8 Recognition of symptoms
- 9 Length of prophylaxis
- 10 Malaria advice sheet given

Patient signature.....Date.....

Nurse signature.....Date.....