

TRINITY HEALTH

TRAVEL HEALTH QUESTIONNAIRE

Please complete this form and return it to the practice nurse at least one week before your first appointment for travel health advice. Please make an appointment at least **EIGHT WEEKS** before your departure – we may be unable to provide travel cover if you do not leave enough time before your departure date. A separate form should be completed for each person traveling.

Name: (please print) _____ Date of Birth: _____

Easiest Contact telephone number _____

PREVIOUS/CURRENT MEDICAL HISTORY

Jaundice	Y/N	Allergies to any drugs or food (ie Eggs, antibiotics, nuts?): _____
Removal of spleen	Y/N	Current health problems: _____ _____
Depression	Y/N	
Psoriasis	Y/N	Current medication: _____
Epilepsy	Y/N	
Liver disorder	Y/N	Radiotherapy/Chemotherapy Y/N If yes give dates _____
Other	Y/N	
Steroids	Y/N	
Pregnant	Y/N	
Pregnancy planned	Y/N	
Well today	Y/N	
Medical Insurance arranged	Y/N	If yes, give details _____
Previous reaction to any vaccines	Y/N	
Feels faint with injection	Y/N	

Please detail all countries to be visited including stopovers and short stays in airport terminals:

Departure Date	Country	City	Rural Area	Coast	Length of stay

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/Friends	Other	
Traveling	Alone	Family/Friends	Group	
Staying in area which is	Urban	Rural	Altitude	
Planned activities	Safari	Adventure	Other	

VACCINATION HISTORY

Have you ever had any of the following vaccinations, and if so when?

Tetanus	Polio	Diphtheria	
Typhoid	Hepatitis A	Hepatitis B	
Meningitis	Yellow Fever	Influenza	
Rabies	Jap B Enceph	Tick Bourne	
Other			

Have you ever had any anti-malarial tablets, if so when, and what type did you have?

For discussion when risk assessment is 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: (patient) _____ Date signed by patient: _____