MISTYLAW MEDICAL PRACTICE TRAVEL QUESTIONNAIRE

Personal Details

NAME:	MALE		DOB:
	FEMALE		

Easiest contact telephone number:

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 illnes including depression or anxiety?

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Women only: Are you pregnant or planning pregancy 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		Diptheria	
Typhoid		Hep A		Hep B	
Meningitis		Yellow Fe		Influenza	
Rabies		Jap B Enc		Tick Borne	

Other:

Malaria Tablets

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 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 ACWY				
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 card supplied

Other

Malaria prevention advice and malaria chemoprophylaxis

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

Further Information

e.g. weight of child
Signed by:_________________________________ **Position:** _________________________________**Date:**___________
Now scan this form into the patient's record on the computer for evidence of best practice