

**PRE-TRAVEL QUESTIONNAIRE**

**Name:** ……………………………………………… **Date of Birth:** …… /…… /…………Male / Female……

**Address:** ………………………………………………………………………………………………………

**Land line:** ……………………………………… **current Mobile:** ……………………………………

**Permission to leave voice mail:** Yes/No (please circle which is applicable)

**Departure Date: …… /…… /………… Return date ……/……/………..Length of Trip………/……/……**

**FOR OFFICIAL USE ONLY**

Date form received in surgery: …… /…… /………… Entered on travel log: …… /…… /…………

Patient No: …………………………………. Appointment date: …… /…… /…………

In order for you to get the best from our travel service we request that you complete a questionnaire **at least 6-8 weeks\*** before your departure date. A separate questionnaire must be completed for each person travelling (including children).

**\***If you are travelling at short notice you should contact the Administration Staff who will advise if it is possible to complete your vaccine schedule prior to your departure**. If it is not possible you may need to book with a private travel clinic.**

Your travel plans will be reviewed by a Nurse and you will be contacted by the nurse or a administrator to arrange an appointment. You may need more than one appointment.

Not all vaccines are provided by the NHS and therefore you may be advised to seek theses from a private clinic. We recommend that you look at the following websites before you attend your appointment: **www.nathnac.org or www.fitfortravel.nhs.net**

Our private vaccine charges are (subject to Change):-

* Hepatitis B £35 single dose
* Rabies £50 per dose
* Meningitis ACWY £40 per dose
* Japanese Encephalitis - Adult £85 per dose

We are a registered Yellow Fever Centre so this vaccination can be given here cost £65.00.

The following vaccines are free on the NHS (subject to Change):-

* Hepatitis A
* Typhoid
* Tetanus, Diphtheria and Polio
* Combined Hepatitis A and Typhoid
* Combined Hepatitis A & B

Payment is required on the day you have your first appointment and is by cash

Before attending for any travel appointment you are advised to seek information from both your travel operator **and** the online travel advice services: [www.fitfortravel.nhs.uk](http://www.fitfortravel.nhs.uk) or [www.nathnac.org/travel](http://www.nathnac.org/travel)

**SIGNED:** …………………………………………………………………. **DATE:** …… /…… /…………

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| **Itinerary and purpose of visit** | | | | | | | | | | | | | |
| Country to be visited (specify area and cities)  (please attach another sheet if necessary) | | | | | Length of stay | | | Holiday type: please state if business or leisure or visiting friends/relatives  Is this a remote location? | | | | | |
| 1. | | | | |  | | |  | | | | | |
| 2. | | | | |  | | |  | | | | | |
| 3. | | | | |  | | |  | | | | | |
| 4. | | | | |  | | |  | | | | | |
| 5. | | | | |  | | |  | | | | | |
| 6. | | | | |  | | |  | | | | | |
| **Please tick as appropriate below to best describe your trip** | | | | | | | | | | | | | |
| 1. Holiday type | | Package | |  | | Self organised | | | |  | Backpacking | |  |
| 2. Accommodation | | Camping | |  | | Cruise ship | | | |  | Trekking | |  |
| Hotel | |  | | Relatives/family home | | | |  | Other | |  |
| 3. Travelling | | Alone | |  | | With family/friend | | | |  | In a group | |  |
| 4. Staying in area which is | | Urban | |  | | Rural | | | |  | High Altitude | |  |
| 5. Planned activities | | Safari | |  | | Adventure | | | |  | Other | |  |
| 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 |  | | Japanese B Encephalitis | | | |  | | Tick Borne Encephalitis | | |  | |
| Other | | | | | | | | | | | | | |
| Malaria Tablets:  Chloroquine/Proguanil/Mefloquine/Doxycycline/Atovaquone+Proguanil (Malarone) | | | | | | | | | | | | | |

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| Personal medical history:  Have you now or ever had any of the following, or is there any history in your family of?  Please circle  Heart problems High blood pressure Diabetes Lung problems Asthma Spinal problems Epilepsy  Do you have any history of mental illness including depression or anxiety? YES/NO  Have you recently undergone radiotherapy, chemotherapy or steroid treatment? YES/NO  Have you had your spleen removed? YES/NO |
| List any current or repeat medications: |
| Do you have any allergies to medication or food (e.g. eggs, antibiotics, nuts)? |
| Have you ever had a serious reaction to a vaccine given to you before? |
| **Women only**: Are you pregnant or planning pregnancy or breastfeeding?  **Children only:** Weight in kg’s |