**Library House Surgery – Travel Health Questionnaire**

**Personal details**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male / Female

Contact telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of trip

Date of Departure: \_\_\_\_\_\_\_\_\_\_\_\_\_ Return date or length of trip: \_\_\_\_\_\_\_\_\_\_\_\_

**Itinerary and purpose of visit**

|  |  |  |
| --- | --- | --- |
| Country to be visited | Length of stay | How close to medical help at destination / remote? |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 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 |  | 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 e.g. 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 illness including depression or anxiety? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |
| **Women only:** Are you pregnant or planning pregnancy 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 |  | Diphtheria |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | 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 recommended and have had the 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 |  |  |  |
| Japanese B Encephalitis |  |  |  |
| Rabies |  |  |  |
| 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) |  |
| Chloroquine |  | Mefloquine |  |
| Doxycycline |  | Malaria advice leaflet given |  |

**Further information**

e.g. weight of child

Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

After completion scan form into patient’s record on the computer for evidence of best practice