Acorn Group Practice – 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