Travel Vaccination Questionnaire

To be completed 6 weeks prior to travel

Full Name DoB

_____

Travel Itinerary

Date	Country	City/Region	Length of stay

Travel Information *please tick all that apply*

Type

	Holiday		Volunteer work		Cruise ship
	Work		Visiting family		Pilgrimage

Accommodation *Please circle*

Hotel Hostel Camping Friends / Family

Activities

- Safari
- Diving
- Adventure sport
- Hiking
- Other_____

Medical History

	Yes	No	Details
Are you fit and well today?			
Any allergies including antibiotics, eggs?			
Any severe reaction to a vaccine before?			
Tendency to faint with injections?			
Any surgical operations in the past to your spleen or thymus?			
Disease that lowers your immunity such as leukaemia, cancer, HIV, organ transplant, autoimmune condition, rheumatological condition?			
Having treatment that lowers your immunity such as radiation, oral steroids, chemotherapy, disease modifying anti-rheumatic drugs (methotrexate etc), stem cell?			
Bleeding or clotting disorders (including DVT)?			
History of Guillain-Barre Syndrome?			
Women Only			
Are you pregnant?			
Are you breastfeeding?			
Are you planning pregnancy while away?			

Vaccination History

	Date		Date		Date
Hepatitis A		Tetanus		Hepatitis B	
Typhoid		Polio		Yellow Fever	
Chickenpox		Diphtheria		Rabies	
Measles		Pertussis		Japanese Encephalitis	

I have answered these questions correctly to the best of my knowledge

Patient / Parent / Guardian _____Date_____

There may be a charge for some vaccines, you will be advised at your appointment of any costs for vaccines.