Please complete this form with as much information as possible as this will help your nurse to assess your travel health needs before your trip. 

**Please return to reception to arrange a Travel Clinic Appointment.**

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth: |  |
| Contact Telephone Number: |  |
| Date of Travel: |  | |
| Length Of stay: |  | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DESTINATION: GIVE DETAILS OF THE COUNTRIES YOU WILL BE VISITING, IN THE CORRECT ORDER, INCLUDING ANY COUNTRY YOU MAY BE PASSING THROUGH** | | | | | | | | |
| **COUNTRY TO BE VISITED** | | | **EXACT LOCATION OR REGION** | **CITY OR RURAL** | | | | **LENGTH OF STAY** |
| 1. | | |  |  | | | |  |
| 2. | | |  |  | | | |  |
| 3. | | |  |  | | | |  |
| Have you taken out travel insurance for this trip? Do you plan to travel abroad again in the future? | | | | | | | | |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY** | | | | | | | | |
| □ Holiday □ Staying in hotel □ Backpacking Additional information  □ Business trip □ Cruise ship trip □ Camping/hostels  □ Expatriate □ Safari □ Adventure  □ Volunteer work □ Pilgrimage □ Diving  □ Healthcare worker □ Medical tourism □ Visiting friends/family | | | | | | | | |
| |  |  |  | | --- | --- | --- | | Are you travelling with : | Family Friends | Alone | | Will you be travelling away from medical help? | Yes | No | | Type of Transport whilst on holiday Eg car, bus, train |  | | |  |  | | | | | | | | | | |
| Website resources: **NaTHNaC will provide you with all your travel information**. | | | | | | | | |
| **Vaccination History:** | | | | | | | | |
| **Please tick any vaccines that you have previously been given and the approximate date (if known),** | | | | | | | | |
| **Vaccination** | | **Date** | **Please note the vaccinations listed are provided on the NHS. For other vaccinations please contact your local private travel clinic or pharmacy**  **Malaria medication is not provided by the NHS and has to be bought from travel clinic/pharmacist** | | | | | |
| Tetanus | |  |
| Polio | |  |
| Diphtheria | |  |
| Hepatitis A | |  |
| MMR | |  |
| Typhoid | |  |
| **Are you currently taking any medication** (Including prescribed, purchased or a contraceptive pill)? | | | | | YES | NO | DETAILS | |
|  | | | | |  |  |  | |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | | |  |  |  | |
| Are you fit and well today | | | | |  |  |  | |
| Any allergies including food, latex, medication | | | | |  |  |  | |
| Severe reaction to a vaccine before | | | | |  |  |  | |
| Tendency to faint with injections | | | | |  |  |  | |
| Any surgical operations in the past, including e.g. your  spleen or thymus gland removed | | | | |  |  |  | |
| Recent chemotherapy/radiotherapy/organ transplant | | | | |  |  |  | |
| Anaemia | | | | |  |  |  | |
| Bleeding /clotting disorders (including history of DVT) | | | | |  |  |  | |
| Heart disease (e.g. angina, high blood pressure) | | | | |  |  |  | |
| Diabetes | | | | |  |  |  | |
| Disability | | | | |  |  |  | |
| Epilepsy/seizures | | | | |  |  |  | |
| Gastrointestinal (stomach) complaints | | | | |  |  |  | |
| Liver and or kidney problems | | | | |  |  |  | |
| HIV/AIDS | | | | |  |  |  | |
| Immune system condition | | | | |  |  |  | |
| Mental health issues (including anxiety, depression) | | | | |  |  |  | |
| Neurological (nervous system) illness | | | | |  |  |  | |
| Respiratory (lung) disease | | | | |  |  |  | |
| Rheumatology (joint) conditions | | | | |  |  |  | |
| Spleen problems | | | | |  |  |  | |
| Any other conditions? | | | | |  |  |  | |
| **Women only** | | | | | | | | |
| Are you pregnant? | | | |  |  |  | | |
| Are you breast feeding? | | | |  |  |  | | |
| Are you planning pregnancy while away? | | | |  |  |  | | |
| Have you undergone FGM / been cut / circumcised | | | |  |  |  | | |
| **To be completed by the nurse:** | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date records reviewed: | |  | | | |
| Completed by: (nurses name) | |  | | | |
| Vaccinations Needed: | | | |  | |
| 1. | | | | 2. | |
| 3 | | | | 4 | |
| 5. | | | | 6. | |
| No Vaccinations needed: |  | | Patient informed: | |  |
| **Appointment date and time:** To be arranged by reception. (This will be cancelled by the nurse if no vaccinations are needed | | | | | |