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. yourspleen 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 |