

THE TRAVEL CLINIC @ ST JOHN'S HEALTH CENTRE
PRIVATE PATIENT TRAVEL QUESTIONNAIRE

To be completed by patient

Name..... Date Of Birth.....

Address

Telephone No Mobile

Departure Date..... Length of stay/holiday.....

Travel Itinerary, including 'stopovers'.....

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Type of holiday:

Type of Accommodation

Staying in resort	
Back Packing	
Trekking	
Safari	
Other	

Hotel	
Self Catering	
Private Home/Family	
Hostel	
Camping	

Current medication (including steroids, chemotherapy, contraception):

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Important medical History (including diabetes, heart or lung conditions)

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Any allergies? eg. Eggs, antibiotics.....

Drug Allergies.....

Have you ever had a bad reaction to a vaccine? Yes/No

Previous Vaccinations/Year Given

***Nurse to Complete
Recommended for this trip***

Tetanus/Diphtheria/Polio	
Japanese Encephalitis	
Hepatitis A	
Typhoid	
Hepatitis B	
Meningitis A&CWY	
Yellow Fever	
Rabies	
MMR	

Females: Are you pregnant? Yes / No
 Do you have any reason to suspect you are pregnant Yes / No

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Nurse to complete

Malaria Prophylaxis

Amount required

Chloroquine & Proguanil	
Chloroquine	
Mefloquine	
Doxycycline	
Malarone	

Patient to read and sign

I have received information on the risks and benefits of the vaccines recommended, read the travel protocol and have the opportunity to ask questions.

I am well today and consent to the vaccines being given

Signed.....

Date.....

SCAN INTO PATIENT'S RECORDS