COURTYARD SURGERY
TRAVEL HEALTH QUESTIONNAIRE

PLEASE HELP US TO HELP YOU STAY WELL WHEN YOU ARE ABROAD, AND REMAIN HEALTHY ON YOUR RETURN. WE RECOMMEND THAT THIS TRAVEL QUESTIONNAIRE BE COMPLETED BEFORE YOUR APPOINTMENT WITH THE PRACTICE NURSE.

The following questions have been included to enable us to obtain relevant information which could influence the advice you are given. The accuracy of the information you provide is vitally important.

Please remember that:

- We have an accurate record of any medications you are currently prescribed at Courtyard Surgery, BUT we may not know about medications you may have been prescribed from hospital, private clinics, or that you have bought over the counter from the pharmacy.
- We have an accurate record of any vaccinations you have received at Courtyard Surgery, BUT we may not have a record of vaccinations you have received eg. At a hospital casualty department, private travel clinic, or previous GP practice.
- We may need to order the vaccine that you require.

We therefore request that you complete this form as accurately as possible and **at least one month** before you are due to travel.

After completing the travel questionnaire, please return it to the reception desk as soon as possible to make an appointment with the Travel Nurse.

It is Courtyard Surgery's policy to advise all patients who have received any immunisation that they may be asked wait in the waiting room for at least 15 minutes to ensure they do not experience any adverse reaction.

Do you have access to the internet ? YES / NO

If you have access to the Internet there are many public websites which will provide current health advice for your chosen destination. You may find the information helpful in your planning.

Useful websites to look at prior to travel:

www.fitfortravel.com

www.8weekstogo.co.uk

SOME VACCINATIONS ARE NOT PROVIDED BY THE NHS. YOU WILL BE ADVISED OF THIS AND ASKED TO PAY FOR THE VACCINE BEFORE IT IS ADMINISTERED.

Personal details details

Name	Date of Birth Male [ ] Female [ ]
Address: Home phone no:……Day time no: ……..…..…… Mobile no:…….……..	

Dates of trip

Date of departure:	Return date or overall length of trip:

Itinerary and purpose of visit

Countries to be visited	**Length of stay**	**Away from medical help at destination, if so, how remote?**
1.		
2.		
3.		

Any future travel plans?

1. Type of trip	Business		Pleasure		Other	
2. Holiday type	Package		Self organised		Backpacking	
	Camping		Cruise ship		Trekking	
3. Accommodation	Hotel		Relatives/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	

Do you have any recent or past medical history of note? (include diabetes, heart or lung conditions)
List any current or repeat medications
Do you have any allergies for example to eggs, antibiotics, nuts or latex?
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 breastfeeding?
Have you taken out travel insurance and if you have a medical condition, have you informed the insurance company?
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 with 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 assessment performed Yes [ ] No [ ]

Travel vaccines recommended for this trip

Disease protection	Yes	No	Patient declined vaccine	Further information
Hepatitis A				
Hepatitis B				
Typhoid				
Cholera				
Tetanus				
Diphtheria				
Polio				
Meningitis ACWY				
Yellow Fever				
Rabies				
Jap B Enceph				
Other				

Travel Advice and leaflets given as per travel protocol

Food water and personal hygiene advice		Travellers' diarrhoea		Blood and bodily fluid infection risks e.g. Hepatitis B	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun & heat protection	
Websites		SMS vaccines reminder service set up			
Travel record and card supplied		Other			

Malaria prevention advice and malaria chemoprophylaxis

Chloroquine and proguanil		Atovaquone + proguanil	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further information

e.g. weight of child

Authorisation for Patient Specific Direction (PSD) Use

Assessor's Name:…… Signature: ……..Date:…….

Prescribers Name: …… Signature: ……..Date: ……..