St Paul's Medical Centre – Travel Information

Complete and return a form for each traveller as soon as possible – 8 weeks before travel if possible.

Name:	Date of birth:
	Male [ ] Female [ ]
E-mail: Do you consent to being contacted on this and other matters by e-mail? Yes [ ] No [ ]	Contact number: Do you consent to being contacted on this and other matters by text? Yes [ ] No [ ]

Date of departure		Total length of trip	
Countries to be visited on this trip (continue overleaf if necessary)	Exact location or region	City or rural	Length of stay
1			
2			
3			
Have you taken out travel insurance for this trip? Yes [ ] No [ ]			
Do you plan to travel abroad again in the future? Yes [ ] No [ ]			
TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK *ALL* THAT APPLY			

[ ] Holiday [ ] Business trip [ ] Expatriate [ ] Volunteer work
[ ] Healthcare worker [ ] Pilgrimage [ ] Safari [ ] Medical tourism
[ ] Adventure [ ] Diving [ ] Visiting friends/family
[ ] Staying in hotel [ ] Backpacking [ ] Camping/hostels [ ] Cruise ship trip

PAST HISTORY OF VACCINES OR MALARIA TABLETS TAKEN

Vaccine	Date	Vaccine	Date	Vaccine	Date
Tetanus/polio/diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		BCG	
Meningitis ACWY		Rabies		Yellow Fever	
Japanese encephalitis		Malaria tablets			
Tick-borne encephalitis					

DETAILS OF CURRENT MEDICATIONS WHETHER PRESCRIBED OR PURCHASED OVER THE COUNTER

Continued overleaf

PERSONAL MEDICAL HISTORY			
	YES	NO	DETAILS
Are you fit and well today			
Any allergies including food, latex, medication			
Do you smoke			
Severe reaction to a vaccine in the past			
Tendency to faint with injections			
Past surgical operations e.g. spleen removed			
Recent chemotherapy, radiotherapy or organ transplant			
Anaemia			
Bleeding/clotting disorders including DVT			
Heart disease e.g. angina, high blood pressure			
Diabetes			
Disability			
Epilepsy/seizures			
Gastrointestinal (stomach) complaints			
Liver or kidney problems			
HIV/AIDS			
Immune system conditions			
Mental health issues including anxiety or depression			
Neurological (nervous system) illness			
Respiratory (lung) disease			
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?			

ANY ADDITIONAL INFORMATION

Date Completed: ____________________ Signed: ______________________________________