**Close Farm Surgery Travel Health Questionnaire**

**Please could you complete this side of the questionnaire, in order for us to assess your immunisation requirements**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of birth** | **Tel No.** | **Date of travel** |

|  |  |  |
| --- | --- | --- |
| **Destination (country)****Please specify region** | **Length of stay** **(nights)** | **Accommodation** |
| **4/5\* hotel** | **Other hotel** | **Family home** | **Camping** | **Safari** | **Other**  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**Mode of travel within the country you are visiting……………………………………………………………………………….**

**Purpose of visit:**

**Holiday Voluntary work Business Expedition School trip Living abroad**

**Do you have any current medical conditions? ………………………………………………………………………………………**

**……………………………………………………………………………………………………………………………………………………………..**

**Do you have any allergies to foods or medicines? ………………………………………………………………………………..**

**…………………………………………………………………………………………………………………………………………………………….**

**Current medications (prescribed and over the counter) ……………………………………………………………………….**

**…………………………………………………………………………………………………………………………………………………………….**

**Previous immunisations (dates if known) …………………………………………………………………………………………….**

**……………………………………………………………………………………………………………………………………………………………..**

**Are you pregnant/planning a pregnancy/breast feeding? …………………………………………………………………….**

**Have you ever suffered from depression/psychiatric condition/epilepsy? ……………………………………………**

**For office use:**

|  |  |  |
| --- | --- | --- |
| **Nurse signature:** | **No appointment required** |  |
| **10/20 min appointment for immunisation**  |  |
| **10/20 min appointment for malaria prevention**  |  |

**Recommended immunisations**

**Name: Destination: Date of travel: Duration:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Dose** | **Req’d** | **Date given** | **Next dose due** | **Vaccine** | **Dose** | **Req’d** | **Date given** | **Next dose due** |
| **Tetanus****Diptheria****Polio** | **1** |  |  |  | **Meningitis****ACWY** |  |  |  |  |
| **2** |  |  |  | **Jap B****Encephalitis**  | **1** |  |  |  |
| **3** |  |  |  | **2** |  |  |  |
| **Booster** |  |  |  | **Hepatitis B** | **1** |  |  |  |
| **MMR** | **1** |  |  |  | **2** |  |  |  |
| **2** |  |  |  | **3** |  |  |  |
| **Hepatitis A** | **1** |  |  |  | **Booster**  |  |  |  |
| **2** |  |  |  | **Cholera** | **1** |  |  |  |
| **Typhoid** |  |  |  |  | **2** |  |  |  |
| **Rabies** | **1** |  |  |  | **Yellow fever** |  |  |  |  |
| **2** |  |  |  | **Other**  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |

**Antimalarial tablets**

**The following tablets are advised for your travel. It is important that you continue taking them for the recommended period of time after leaving the malaria area. A leaflet will be provided containing advice on bite avoidance**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Tablet** | **Dose per day/week** | **No. of weeks** | **Start date** | **Finish date**  |
| **Chloroquine** | **2 weekly** |  |  |  |
| **Proguanil** | **2 daily** |  |  |  |
| **Malarone** | **1 daily** |  |  |  |
| **Mefloquine** | **1 weekly** |  |  |  |
| **Doxycycline** | **1 daily**  |  |  |  |

**Should you develop a fever within one year of travel, you should consult your GP, so that the risk of malaria can be ruled out**