**AWBURN HOUSE TRAVEL QUESTIONNAIRE**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Destination (including ‘stop-overs’ however brief)**

**Date of Travel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Return:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Type of travel: Tourist Y/N Back packing Y/N Working Y/N**

**Will you be more than 24 hours away from a hospital Y/N**

**If Yes, please give details**

**Allergies Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Conditions Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Females Are you pregnant Yes/No**

**Please hand in the completed questionnaire at reception, the Nurse will contact you with an appointment.**

**In the case of travel where MenACWY is needed a prescription will be issued.**

**Malaria tablets are either a private prescription or bought at a chemist.**

**Some vaccinations need a Private Travel Clinic; you will be advised about this.**

**For the Practice nurse to complete**

|  |  |  |
| --- | --- | --- |
| **PREVIOUS TRAVEL VACCS** | **DATE of previous vaccination** | **Needs /advice** |
| **Dip/tet/polio** |  |  |
| **Hep A** |  |  |
| **Typhoid** |  |  |
| **Hep B** |  |  |
| **Men ACWY** |  |  |
| **Rabies** |  |  |
| **Yellow fever** |  |  |
| **Cholera** |  |  |
| **Dengue Fever** |  |  |
| **Schistosomiasis** |  |  |
| **Jap. Encephalitis** |  |  |