

Travel Assessment Form

Fields marked with an asterisk (*) are compulsory.

Please use this form if you are travelling abroad and may require vaccinations. Make sure you hand this form in at least 6 weeks before you are due to travel, to allow for any arrangements to be made.

Patient Details

Title (Mr. Mrs. etc.) *Date of Birth

*Surname

*Forename(s)

*Sex Assigned at Birth Male Female Other

*Gender Male Female Other

*Phone

E-mail

Trip Details

*Departure Date

*Trip Duration

*Which country/countries are you visiting? Please include how long you intend to be in each country, and how far away from medical help you will be.

Trip Description

*What is the purpose of your trip?

Holiday

Business

Other

Please Specify

*What type of trip is it? Please tick all that apply.

Package Holiday

Camping

Self-Organised

Trekking

Back-packing

Cruise Ship

Other

Please Specify

*Where will you be staying?

Hotel

Friends or Family

Other

Please Specify

*Who will you be travelling with?

Alone

With Friends or Family

With a Group

*What sort of area will you be staying in?

Urban (city/town)

Rural (countryside)

Altitude (mountains)

*What sort of activities will you be doing?

Safari

Adventure

Beach/Pool

Other

Please Specify

Your Medical History

*Please list any long-term or chronic medical conditions you have (e.g. Heart disease, asthma, diabetes etc).

*Please list any current medications that you take (including oral contraception).

*Please list any allergies you have.

*Have you had a serious reaction to a vaccine in the past? If yes, please give details.

Yes No

*Does having an injection make you feel faint? Yes No

*Have you recently had an infection (e.g. cold or high temperature)? Yes No

*Do you or any close family members have epilepsy? Yes No

*Do you have any history of mental illness, including depression and anxiety?
 Yes No

*Have you recently undergone Chemotherapy, Radiotherapy, or Steroid Treatment?
 Yes No

*Are you pregnant, planning a pregnancy, or breast feeding? Yes No

Please add any further information you feel may be relevant:

Insurance

*Have you taken out Travel Insurance for your trip? Yes No

*Have you told your Insurance Company about any medical conditions you have?

Yes No

Vaccination History

*Have you ever had any of the following vaccinations/tablets? Please tick as many as apply.

Diphtheria

Hepatitis A

Hepatitis B

Japanese B Enceph

Influenza

Malaria

Meningitis

Polio

Rabies

Tick Borne

Typhoid

Yellow Fever

*Have you had a Covid-19 Vaccination?

No

1st Dose

2nd Dose

Date of last dose

Signature

*Signature

*Date