Mayfield Medical Practice
Travel Form

Name:	Date of birth: Male ( ) female ( )
Easiest contact telephone number:	
Email address:	
Dates of Trip	
Date of Departure:	
Return date or overall length of trip:	

Itinerary and purpose of visit		
Country to be visited	Length of stay	Away from medical help at destination. If so, how remote?
1.		
2.		
Future travel plans		

Please tick as appropriate below to best describe your trip						
Type of trip	Business		pleasure		Other	
Holiday type	Package		Self organised		Backpacking	
	camping		Crusie ship		Trekking	
Accomodation	Hotel		Relatives/family home		Other	
Travelling	Alone		With family/friend		In a group	
Staying in area which is	Urban		Rural		Altitude	
Planned activities	Safari		Adventure		Other	

Personal medical history
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)
List any current or repeat medications
Do you have any allergies? For example to eggs, antibiotics or nuts?
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 anxiety or depression?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
Women only: Are you pregnant, planning pregnancy or breastfeeding?
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?
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 within 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 the opportunity to ask questions. I consent to the vaccines being given.

Signed: ______________________________ Date: ____________.

For official use only
Patient name:
Travel risk assessment performed Yes ( ) No ( )

Travel vaccines recommended for this trip			
Disease protection	Yes	No	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

Travel advice and leaflets given as per travel protocol		
Food/water and personal hygiene advice ( )	Travellers' diarrhoea ( )	Hepatitis B and HIV ( )
Insect bite prevention ( )	Animal Bites ( )	Accidents ( )
Insurance ( )	Air travel ( )	Sun and heat protection ( )

Malaria prevention and malaria chemoprophylaxis	
Chloroquine and proguanil ( )	Atovaquone and proguanil (Malarone) ( )
Chloroquine ( )	Mefloquine ( )
Doxycycline ( )	Malaria advice leaflet given ( )

Weight of child if required:
Signed by: **Position:** **date:**