GARTHDEE MEDICAL GROUP

PRE-TRAVEL HEALTH & VACCINATION ASSESSMENT

Surname _____

Forename _____

Telephone number _____

Date of Birth _____

M/F _____

1. What is your departure date?

   _____

2. How long will you be away?

   _____

3. Which countries do you intend to visit? (Including brief stopovers)

   _____

   _____

   _____

4. Will your journey take you to the:

   - coast ☐
   - interior ☐
   - islands ☐

5. Will you be staying in:

   - tourist hotels ☐
   - relatives' homes ☐
   - local accommodation ☐

6. Are you travelling with:

   - family ☐
   - partner ☐
   - alone ☐
   - group ☐

7. Are you going on:

   - an organised package tour ☐
   - organising it yourself ☐
   - taking a backpacking holiday ☐

8. Is your holiday for:

   - pleasure ☐
   - business ☐
   - for a period of voluntary service in a remote area ☐

9. Will you be going on safari, travelling in areas with poor communication or participating in adventure sports

   Yes ☐ No ☐ If yes please give details

   _____

   _____

10. Will you be in areas where medical help is non-existent (even for a short period)?

    Yes ☐ No ☐ If yes please give details

    _____

    _____

11. Are you suffering from any minor ailments?

    Yes ☐ No ☐ If yes please give details

    _____

    _____

12. Do you have any long-term medical conditions?

    Yes ☐ No ☐ If yes please give details

    _____

13. Do you have a history of epilepsy?

    Yes ☐ No ☐ If yes please give details

    _____

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14. Have you ever experienced anxiety, depression or other psychological problems which have required treatment?

Yes ☐ No ☐ If yes please give details

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15. Have you had your spleen removed?

Yes ☐ No ☐ If yes please give details

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16. Have you ever had a bad reaction to a vaccine?

Yes ☐ No ☐ If yes please give details

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17. Do you have any other allergies, e.g. eggs?

Yes ☐ No ☐ If yes please give details

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18. Are you taking any medication including the oral contraceptive pill, or have you been on antibiotics within the last 10 days?

Yes ☐ No ☐ If yes please give details

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19. Are you pregnant, breast-feeding or planning pregnancy?

Yes ☐ No ☐ If yes please give details

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20. Are you HIV positive?

Yes ☐ No ☐ If yes please give details

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21. Have you recently received treatment with radiotherapy, chemotherapy or steroids?

Yes ☐ No ☐ If yes please give details

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22. Are any children who are travelling up to date with their childhood vaccinations?

Yes ☐ No ☐ If no please give details

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23. Have you previously had any vaccinations?

Yes ☐ No ☐

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24. Have you had any of the following vaccinations and, if so, when?

Typhoid	☐	Meningitis	☐
Tetanus	☐	Rabies	☐
Polio	☐	Japanese Encephalitis	☐
Yellow Fever	☐	Tick-borne Encephalitis	☐
Hepatitis A	☐	Diptheria	☐
Hepatitis B	☐		

Vaccines Required	**Vaccines Given**
1.	
2.	
3.	
4.	
Malaria Prophylaxis: Yes ☐ No ☐	
Product:	

I consent to the above vaccinations the nature of which have been explained to me by

……

Patient's Signature ……. Date ……

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