

DUNDONALD MEDICAL CENTRE

Personal Details					
Name:				Date of Birth: Male [] Female []	
Easiest contact telephone number:					
Email address:					
Details 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 below, as appropriate, to best describe your trip					
1. Type of trip	Business		Pleasure		Other
2. Holiday type	Package		Self-organised		Backpacking
	Camping		Cruise ship		Trekking
3. Accommodation	Hotel		Family home		Other
4. Travelling	Alone		Family/friend		In a group
5. Staying in area which is	Urban		Rural		Altitude
6. Planned activities	Safari		Adventure		Other
Personal Medical History					
Do you have any recent medical history of note? (including diabetes, heart or lung conditions)					
List any current or repeat medications					
Do you have any allergies? (e.g. eggs, antibiotics, nuts)					
Have you ever had a serious reaction to a vaccine ?					
Does having an injection make you feel faint?					
Do you or any close family member have epilepsy?					
Do you have any history of mental illness including depression or anxiety?					
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?					
Women only: Are you pregnant or planning pregnancy or breast-feeding?					
Have you taken out travel insurance and, if you have a medical condition, informed the insurance company about it?					
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 I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given:

Signed: _____ Date: _____

For Official Use:					
Patient's 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		Traveller's diarrhoea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Websites		Travel record card supplied			
		Other			
Malaria Prevention advice and malaria chemoprophylaxis					
Chloroquine and proguanil		Atovaquone and proguanil (Malarone)			
Chloroquine		Mefloquine			
Doxycycline		Malaria Advice leaflet given			
Further Information					
e.g Weight of child:					

Signed By: _____ Position: _____

Date: _____