

## WELLS CITY PRACTICE – FOREIGN TRAVEL QUESTIONNAIRE

<b>Personal details</b> Name:	<b>Date of birth:</b> Male [ ] Female [ ]								
<b>Dates of trip</b> Date of departure:	Date of return:								
<b>Itinerary and purpose of visit</b> Countries to be visited: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%;">                     1.                      2.                      3.                 </div> <div style="width: 35%;">                     Length of stay:                 </div> </div>									
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><b>Type of trip</b> (please tick)</td> <td style="width: 50%;"><b>Accommodation</b> (please tick)</td> </tr> <tr> <td>Holiday <input type="checkbox"/></td> <td>Hotel <input type="checkbox"/></td> </tr> <tr> <td>Business <input type="checkbox"/></td> <td>Private house <input type="checkbox"/></td> </tr> <tr> <td>Other <input type="checkbox"/></td> <td>Camping/back packing <input type="checkbox"/></td> </tr> </table>		<b>Type of trip</b> (please tick)	<b>Accommodation</b> (please tick)	Holiday <input type="checkbox"/>	Hotel <input type="checkbox"/>	Business <input type="checkbox"/>	Private house <input type="checkbox"/>	Other <input type="checkbox"/>	Camping/back packing <input type="checkbox"/>
<b>Type of trip</b> (please tick)	<b>Accommodation</b> (please tick)								
Holiday <input type="checkbox"/>	Hotel <input type="checkbox"/>								
Business <input type="checkbox"/>	Private house <input type="checkbox"/>								
Other <input type="checkbox"/>	Camping/back packing <input type="checkbox"/>								
<b>Medical History</b> Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions).									
Please list any current or repeat medications									
Do you have any allergies (eg. Eggs, antibiotics, nuts etc)									
Have you ever had a serious reaction to a vaccine given to you before?									
Does having an injection make you feel faint?									
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?									
<i>Women only:</i> 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 this?									

Please add any further information which you think 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	
Malaria tablets:			Other:		

For discussion when risk assessment if performed during your appointment.

**Declaration must be signed in the nurse's presence during the 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 had the opportunity to ask questions. I consent to the vaccine being given.

**Signed:** ..... **Date:** .....

**To be completed by the Nurse**

<b>Patient name:</b>			
<b>Travel risk assessment performed</b>		<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
<b>Travel vaccinations recommended for this trip</b>			
Disease protection	Yes	No	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			
<b>Malaria prevention advice and malaria chemoprophylaxis</b>			
Choloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

**Signed by:** ..... **Date:** .....  
**Practice Nurse**