**Barns Medical Practice**

**Travel Health Questionnaire**

*One form to be completed per traveller*

*(Form to be emailed to: Clinical\_Practice\_BarnsMedicalPractice\_80081@aapct.scot.nhs.uk)*

|  |  |
| --- | --- |
| Name:       | Date of Birth:       |
| Address:         |
| Email:       | Contact Number:       |
|  |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW** |
| Date of Departure:       | Total Length of Trip:       |
| Country to be visited  | Exact Location  | City or Rural  | Length of Stay  |
| 1.       |       |       |       |
| 2.       |       |       |       |
| 3.       |       |       |       |
| 4.        |       |       |       |
| 5.       |       |       |       |
|  |
| **Type of Trip -** Please provide details below to best describe your trip  |
| **Type of Trip**  | Package  | [ ]  | Self Organised  | [ ]  | Backpacking  | [ ]  |
| Camping  | [ ]  | Cruise Ship | [ ]  | Trekking | [ ]  |
| **Reason for Travel** | Business | [ ]  | Pleasure | [ ]  | Other  | [ ]  |
| **Accommodation**  | Hotel | [ ]  | Camping  | [ ]  | Family/Friends | [ ]  |
| **Travelling** | Alone  | [ ]  | Family/Friends  | [ ]  | Group  | [ ]  |
| **Type of Area**  | Urban Coastal | [ ]  | Rural Inland | [ ]  | Altitude Jungle  | [ ]  |
| **Planned Activities**  | Safari | [ ]  | Adventure  | [ ]  | Other  | [ ]  |
|  |
| **PERSONAL MEDICAL HISTORY**  |
| Please list any medication you are currently taking:       |
| Please supply information on any vaccines or malaria tablets taken in the past  |
| Tetanus/Polio/Diptheria  |       | MMR |       | Influenza |       |
| Typhoid  |       | Hepatitis A  |       | Pneumococcal  |       |
| Cholera  |       | Hepatitis B  |       | Meningitis  |       |
| Rabies  |       | Japanese Encephalitis |       | Tick Borne Encephalitis  |       |
| Yellow Fever  |       | BCG |       | Other |       |
| Malaria Tablets  |       |  |
|  | **Yes** | **No**  | **Details** |
| Are you allergic to anything? (e.g. eggs, nuts, antibiotics) If so, please specify: | [ ]  | [ ]  |       |
| Have you ever had a reaction to any vaccine or tablets given? If so, please specify: | [ ]  | [ ]  |       |
| Tendency to faint with injection  | [ ]  | [ ]  |       |
| Any surgical operations in the past, including e.g spleen or thymus gland removed | [ ]  | [ ]  |       |
| Recent chemotherapy/radiotherapy/organ transplant  | [ ]  | [ ]  |       |
| Anaemia  | [ ]  | [ ]  |       |
| Bleeding/Clotting disorders (including DVT)  | [ ]  | [ ]  |       |
| Heart disease e.g. angina, high blood pressure | [ ]  | [ ]  |       |
| Diabetes  | [ ]  | [ ]  |       |
| Disability  | [ ]  | [ ]  |       |
| Epilepsy/Seizures | [ ]  | [ ]  |       |
| Gastrointestinal (stomach) complaints | [ ]  | [ ]  |       |
| Liver or kidney problems  | [ ]  | [ ]  |       |
| HIV/AIDS | [ ]  | [ ]  |       |
| Immune System condition  | [ ]  | [ ]  |       |
| Mental Health issues (including anxiety, depression) | [ ]  | [ ]  |       |
| Neurological(nervous system) illness | [ ]  | [ ]  |       |
| Respiratory (lung) disease | [ ]  | [ ]  |       |
| Rheumatology (joint) conditions | [ ]  | [ ]  |       |
| Spleen problems | [ ]  | [ ]  |       |
| Any other Conditions?       |
| **Women Only**: Are you pregnant or breastfeeding?       |

Signed: Date:

|  |
| --- |
| **FOR OFFICE USE ONLY**  |
| **Is the patient fit and well today?** | **Yes**  |  | **No**  |  |
| **Name of Vaccine**  | **Dose** | **Batch Number**  | **Site given**  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Vaccine given by:**

**Doctor’s Signature:**

**Date:**