**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:**