Meddygfa Beech House **69 Stryd Y Foel, Dinbych, Sir Ddinbych, LL163AY**
Beech House Surgery 69 Vale Street, Denbigh, Denbighshire, LL16 3AY
Tel/Rhif Ffon: 01745 812863 Fax/Ffacs 01745 816574
E-mail/E-bost: enquiries.w91033@wales.nhs.uk

Travel Questionnaire

Please complete the following medical questionnaire and attached consent form. This will be assessed by one of our travel vaccination nurses to determine which vaccination is appropriate. It will then be assessed by one of our doctors, who will ensure you are safe to receive the vaccine. You will then be contacted with the price of your vaccination and an appropriate appointment time to receive your vaccination. Please ensure you bring the correct payment with you to this appointment. Please be prepared for your travel and allow 6-8 weeks for your vaccination program.

YOUR DETAILS:

Your Name (required)

Your Email (required)

Your Daytime Tel Number (required)

Your Postcode (required)

Your Date of Birth (required)

Sex

Male Female

TRIP DATES:

Departure (required)

Duration(required)

TRIP ITINERARY:

Country 1 (required)

Duration (required)

Availability of Medical Help

Country 2

Duration

Availability of Medical Help

Country 3

Duration

Availability of Medical Help

TRIP DESCRIPTION: (Please tick all appropriate boxes)

Purpose of Trip: ☐ Business ☐ Pleasure ☐ Other

Type of Trip: ☐ Package ☐ Camping ☐ Backpacking ☐ Cruise Ship ☐ Trekking ☐ Self-Organised

Accommodation: ☐ Hotel ☐ Friends/Family ☐ Other

Travelling: ☐ Alone ☐ With Friends/Family ☐ In a Group

Location Type: ☐ Urban ☐ Rural ☐ Altitude

Activity Type: ☐ Safari ☐ Adventure ☐ Other

PERSONAL MEDICAL HISTORY:

List all chronic medical conditions that you have (eg. diabetes, heart or lung conditions)

List all allergies that you have (eg. eggs, nuts, antibiotics)

If you have had a serious reaction to a vaccine in the past, which vaccine was it?

List all of your current medications (including oral contraception)

Have you recently suffered from any infection (e.g heavy cold, flu or high temperature)?

Yes ☐

Does having an injection cause you to feel faint?

Yes ☐

Do you or any close family members have epilepsy?

Yes ☐

Do you have any history of mental illness including depression or anxiety?

Yes ☐

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Yes ☐

Have you taken out travel insurance?

Yes ☐

If you have a medical condition, have you told your insurance company about it?

Yes ☐

Are you pregnant, planning pregnancy or breast feeding?

Yes ☐

Write below any further information that might be relevant

PLEASE LIST YOUR VACCINATION HISTORY:

Have you ever had any of the following vaccinations / tablets and if so, when?

Tetanus

Yes ☐ When

Diphtheria

Yes ☐ When

Hepatitis A

Yes ☐ When

Meningitis

Yes ☐ When

Influenza

Yes ☐ When

Jap B Enceph

Yes ☐ When

Malaria Tablets

Yes ☐ When

Polio

Yes ☐ When

Typoid

Yes ☐ When

Hepatitis B

Yes ☐ When

Yellow Fever

Yes ☐ When

Rabies

Yes ☐ When

Tick Borne

Yes ☐ When

Other

Yes ☐ When

I …… confirm that the above information is correct

Signed ……

Date ……