Regent Street Surgery

Travel Health Questionnaire

We recommend you submit this form 6 weeks prior to travel

Personal Details	
Name:	Date of Birth:

Dates of Trip	
Date of Departure:	
Length of Trip	

Itinerary – (if more than 2, please continue on another sheet)		
Countries to be visited: Including transits	Length of Stay	>24 hrs from medical help

Purpose of Trip (Please tick below to best describe your trip)								
Type of Trip:	Business		Pleasure		Other		Urban	
Holiday Type:	Package		Backpacking		Cruise		Rural	
Planned Activities:	Altitude		Adventure		Ski			

Personal Medical History	Please Tick	
Allergies e.g. eggs/nuts/latex?	YES	NO
Serious reaction to previous vaccination?	YES	NO
Recent radiotherapy, chemotherapy or steroid treatment?	YES	NO
WOMEN ONLY: Pregnant, planning a pregnancy or breastfeeding?	YES	NO
Have you been to a country with the Zika virus in the last 12 months?	YES	NO

Vaccination History			
Have you ever had any of the following vaccinations?	Date	Vaccines recommended	Charges
Tetanus			No charge
Diptheria			No charge
Polio			No charge
Typhoid			No charge
Hepatitis A			No charge
Hepatitis B			£42 per dose (Full course = 3 doses)
Meningitis ACWY			£55
Yellow fever			£62
Rabies			£55 per dose (Full course = 3 doses)
Jap B Encephalitis			£55 per dose (Full course = 2 doses)
Tick Borne Encephalitis			Not available here
MMR			No charge
BCG (Tuberculosis)			No charge
Other			

Malaria Prevention/Prophylaxis	**Please discuss malaria prevention/prophylaxis with nurse at appointment £18.00 charge for a private prescription.**

Malarone		Doxycycline		Proguanil	
Chloroquine		Mefloquine			

Consent – I have received information on the risks and benefits of the vaccinations and give consent to the vaccines being given. I confirm that I have disclosed my full medical history

Patient Signed:		Date:
Nurse:	Signed:	Date:

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If you are not a registered patient at Regent Street Surgery, please fill in the following questions.

Name of your GP surgery: ____

Address and contact number of your GP surgery. Please state below.

Do you have any allergies? Please list any below.

Do you take any medication? Please list any below.

Please list any current or past medical history.
(please include any past or current conditions making special note of any diagnoses of: epilepsy, psychiatric illness, auto-immune diseases or whether you have ever undergone radio or chemotherapy.)

Please provide the best contact number when we need to contact you:

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