

Pre Travel Risk Assessment / Travel Vaccination Advice

About you

Name		M / F
Address		
Post Code	Tel No	Date of Birth

Please give brief details of any of the following:

Recent / current steroid treatment	
Chemotherapy or Radiation treatments	
Any major abdominal surgery	
History of Epilepsy	History of Depression
Sever allergic reactions to medications / eggs	
Any adverse reactions to any Vaccinations / Injections?	
Adverse reactions to insect bites	

Female patients only

Are you currently breast-feeding?	Yes / No	Are you taking oral contraceptive pills?	Yes / No
Are you / do you plan to become pregnant in the near future?			Yes / No

Previous vaccination history

Have you had a full course of any of the following Vaccinations?							
	Yes	No	Date given		Yes	No	Date given
Diphtheria				Polio			
Hepatitis A				Rabies			
Hepatitis B				Tetanus			
Japanese Encephalitis				Tick Borne Encephalitis			
Meningitis A				Tuberculosis			
Meningitis ACWY				Typhoid			
Meningitis C				Yellow Fever			
MMR							
Previous Anti-Malaria Treatments (please give details)							

About your travel abroad

Destination (s)					
Date of departure				Duration of stay	
Reason for travel	Holiday	Business	Voluntary work	Expedition	Visiting Family
Type(s) of area you are visiting	Cities	Towns	Rural	Swamps	Mountainous
Type of accommodation	Hotel	Camping	Self catering	Backpacking	Trekking
	Staying in house with friends/family		Other (Please specify)	Medical insurance arranged? Yes / No	

For Office use only

Vaccination Recommendations

Total cost of Recommendations £

Diphtheria + Tetanus Booster	Hep A / Booster	Hep B / Booster	Jap Enc	Men A + C
Men ACWY	Polio / Booster	Rabies	Tick Borne Enc	TB
Typhoid	Yellow Fever			
Malaria prophylaxis Indicated Yes / No		Recommendation		
Name of Nurse		Signed		Date