

PRE-TRAVEL ASSESSMENT

Your appointment is with _____ on ____ / ____ / ____

YOUR DETAILS

Name: _____ Date of Birth ____ / ____ / ____

Address: _____

Occupation: _____ Departure ____ / ____ / ____ Return: ____ / ____ / ____

I will be accompanied by: _____ (ie partner, friend, group, work related)

HEALTH BACKGROUND

Your Doctors Name: _____ Do you believe you are fit to travel: YES / NO

Please list your known medical conditions _____

Any history of hepatitis, jaundice, ear, hearing or clotting problems _____

Please list your current medications _____

Please list your known allergies (medications, vaccines, eggs etc) _____

Do you have travel health insurance: YES / NO

WOMEN: could you be pregnant while abroad? YES / NO

Warning: Some anti-malarial medications may be unsuitable in pregnancy

PLEASE INDICATE IN WHICH YEAR YOU HAVE RECEIVED THE FOLLOWING VACCINES: (You may need to check with your Doctor)

Vaccine given	Year	Vaccine given	Year	Vaccine given	Year
Tetanus / Diphtheria / Whooping cough (pertussis)		Typhoid		Mantoux / BCG	
Polio		Cholera		Meningococcal	
Flu vaccine		Hepatitis B		Japanese Encephalitis	
Pneumovax		Hepatitis A Vaccine		Q fever	
Measles / Mumps / Rubella		Hepatitis A immunoglobulin		Rabies	
Varicella (Chicken Pox)		Hepatitis A-B		Yellow fever	

YOUR ITINERARY

I will visit the following countries:

Country (in order of visit)	Durations (weeks)	Accommodation (hotel / tent / backpack)	Cities only

PLEASE BRING THIS COMPLETED PAGE TO YOUR APPOINTMENT