

Waterside Medical Centre

TRAVEL VACCINATION QUESTIONNAIRE

Personal Details

Name: _____ D.O.B. _____ E-Mail: _____

Date of Trip

Date of departure: _____ Date of return: _____

Itinerary

Country to be visited	Length of stay	Remote location?
1.		
2.		
3.		
4.		
5.		

Personal Medical History

Do you have any allergies, for example to eggs, nuts, antibiotics? YES / NO

If yes, please provide details: _____

Have you ever had a serious reaction to a vaccine given to you before? YES / NO

If yes, please provide details: _____

Does having an injection make you feel faint? YES / NO

Do you or any close family members have epilepsy? YES / NO

Do you have any history of mental illness including depression or anxiety? YES / NO

Have you recently undergone radiotherapy, chemotherapy or steroid treatment? YES / NO

Women Only: Are you pregnant or planning pregnancy or breast feeding? YES / NO

Have you taken out travel insurance, and if you have a medical condition, informed the insurance company about this? YES / NO

Additional Information

Please use the space below for any additional information you feel may be relevant:

PLEASE BRING THIS WITH YOU TO YOUR APPOINTMENT WITH THE PRACTICE NURSE