Travel Consultation Checklist

Date: _____

Personal Details		
Name:	Date of Birth:	Male □ Female □
Telephone number:	Email Address:	

Dates of Trip	
Departure Date:	Return Date:

Itinerary & Purpose of Visit	
Country(s) to be visited;	Length of Stay:
1.	
2.	

Please tick appropriate below to best describe your trip;					
Type of Trip;	Business □	Pleasure □	Other □		
Holiday Type;	Package □	Self Organized □	Backpacking □	Trekking □	
Accommodation;	Hotel □	Relatives/family home □			
Travelling;	Alone □	With family/friend □			
Staying in Area;	Urban □	Rural □			

Travel Medicine History
List any current medications;
Do you have any recent or past medical history of note? Yes □ No □ (including diabetes, heart or lung conditions)
Do you have any allergies e.g. nuts, eggs, antibiotics etc.? Yes □ No □
Have you ever had a serious reaction to a vaccine given to you before? Yes □ No □
Does having an injection make you feel faint? Yes □ No □
Are you pregnant, trying to conceive or breastfeeding? Yes □ No □
Have you ever had any of the following vaccines? If yes, please state date… Typhoid □ _____ Diphtheria / Tetanus □ _____ Hepatitis A □ _____ Hepatitis B □ _____ Influenza □ _____ Yellow fever □ _____ Polio □ _____ Rabies □ _____

For Official Use:

Travel Vaccine(s) Recommended for this Trip;

Hepatitis A □ Hepatitis B □ Tetanus / Diphtheria □ Yellow Fever □
Typhoid □ Malaria tablets □ *Other* □ (**Doctors Initials:**_____)