WOODLANDS PRIMARY CARE

Travel Vaccines & Health: Assessment Form

Please read carefully and answer each question fully. Please fill in one form per person.

Name: _____

Date of Birth: _____

Address: _____

Contact Number: _____

Email: _____

Have you had travel vaccines before? (circle as appropriate)

YES / NO / DON'T KNOW

Have you ever had an allergic reaction to a vaccine? (circle as appropriate)

YES / NO / DON'T KNOW

If yes, please give details: _____

_____

Do you know what medicine(s) or vaccine(s) you need for this trip? (circle as appropriate)

YES / NO

If yes, please give details: _____

_____

Which country/countries are you travelling to?

_____

What region(s) in the country/countries are you travelling to?

_____

Have you been to these countries before? (circle as appropriate)

YES / NO

What are your travel dates (departure and return)?

Depart on: _____

Return on: _____

Why are you travelling? Please circle all that apply;

Holiday, Adventure Sports, Backpacking, Business, Diving, Family Gathering, Healthcare Work, Honeymoon, Medical Treatment, Pilgrimage, Study, Volunteer Work

Where will you stay? Please circle all that apply;

City or Urban, Beach Resort, Safari, Desert, Jungle or Rainforest, Rural or Remote, Sailing or Cruising, Mountains

What is your accommodation like? Please circle all that apply;

Hotel, Bed & Breakfast or Apartment, Hostel, Homestay, Lodging, Camping, Family Home

Will you be spending time at an altitude of more than 3000 metres or 9842 feet?

YES / NO / DON'T KNOW

Do you have travel insurance?

YES / NO

If you are travelling in Europe, do you have an EHIC card?

YES / NO / NOT APPLICABLE

Are you planning on getting your partner pregnant within 6 months of travel?

YES / NO / DON'T KNOW

Have you ever had a blood clot in your leg (DVT) or lung (PE) before?

YES / NO / DON'T KNOW

If yes, please give details: _____

_____

Will you be travelling for more than 5 hours?

YES / NO / DON'T KNOW

If yes, please give details: _____

_____

Do you have low immunity because of a medical condition or medication?

YES / NO

If yes, please give details: _____

_____

Will you be travelling with any prescription medicines from your doctor?

YES / NO

If yes, please give details: _____

_____

Will you be travelling with any over-the-counter medicines?

YES / NO

If yes, please give details: _____

_____

Will you be travelling with controlled drugs prescribed by your doctor?

YES / NO

If yes, please give details: _____

_____

Are you allergic to eggs?

YES / NO

Are you allergic to latex?

YES / NO

Do injections make you faint or feel nervous?

YES / NO

Have you already checked travel health websites (like NaTHNaC Travel Health Pro or Fit For Travel) for advice?

YES / NO

Please list any further information we need to know in the box below;

For Office Use Only

Completed form brought in on (date): _____

Please pass to scanning once complete. The form will need to be workflowed to the Practice Nurses for review.

Updated July 2023