SCOTT ROAD MEDICAL CENTRE

TRAVEL HEALTH

Please complete this form and return to the Surgery as soon as possible.
Please telephone 01904 724400 for instructions after 7 working days.

PATIENT INFORMATION		
Surname	**First Name**	**Date of Birth**
Address	**Telephone Number**	**G.P.**
	Home : **Mobile :**	
Present Occupation :		

TRAVEL ITINERARY			
	Country	**City/Resort**	**Duration of Stay**
Date of Departure			

Reason for Visit (e.g. Holiday, Business (indicate type of work), Backpacking, Other)	
Accommodation (e.g. Hotel, Hostel, Camping)	

MEDICAL AND VACCINATION HISTORY

Please list regular medications (including the pill and over-the-counter medication)	
Allergies	
Pregnant or Planning Pregnancy ?	**Yes / No**
Do You Smoke ? / If So, How Many ?	

FOR ADVICE AND SUPPORT ON QUITTING SMOKING PLEASE BOOK AN APPOINTMENT WITH OUR HEALTH CARE ASSISTANT

Any Serious Illnesses or Operations ?	

Previous Vaccinations (if known)

Vaccinations	Date Received	Vaccinations	Date Received
Tetanus		**Yellow Fever**	
Diphtheria		**Rabies**	
Polio		**Hepatitis B**	
Typhoid		**Other**	
Hepatitis A			

Nurse to Complete

VACCINES RECOMMENDED				Date Completed	
				Completed By	
	TICK BOX				
	Not Needed	Date Had	Needed	COMMENTS	
Tetanus					
Diphtheria					
Polio					
Hepatitis A					
Typhoid					
Other (please list)					

ANTI-MALARIAL

Comments :

Chloraquine	
Proguanil	
Malarone	
Mefloquine	
Doxycycline	

TRAVEL ADVICE GIVEN	YES/NO