**ONCE COMPLETING THIS FORM, PLEASE CONTACT THE SURGERY AFTER ONE WEEK**

# TRAVEL HEALTH ASSESSMENT FORM

## JACEY & DICKENS HEATH SURGERY FOR REGISTERED PATIENTS

***This form must be completed and returned to the surgery 6 weeks before departure date***

| | | |
|---|---|---|
| Name: | Date of Birth: | |
| | ☐ Male | ☐ Female |
| Address: | Telephone Number: | |
| Email: | Mobile Number: | |

**Please supply information about your trip in the sections below**

| | |
|---|---|
| **Date of Departure**: | Total length of trip: |

| Country to be visited | Exact location / region | City or Rural | Length of stay |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

Have you taken out travel insurance for this trip?

Do you plan to travel abroad again in the future?

**Type of travel and purpose of trip**

| | | | |
|---|---|---|---|
| ☐ Holiday | ☐ Staying in hotel | ☐ Backpacking | **Travelling with:** |
| ☐ Business trip | ☐ Cruise ship trip | ☐ Camping / Hostels | ☐ Alone |
| ☐ Expatriate | ☐ Safari | ☐ Adventure | ☐ Friends / Family |
| ☐ Volunteer work | ☐ Pilgrimage | ☐ Diving | ☐ Group |
| ☐ Healthcare worker | ☐ Medical tourism | ☐ Visiting friends/ family | ☐ Other |

**Please supply details of your personal medical history**

| | Yes | No | Details |
|---|---|---|---|
| Any allergies including food, latex, medication? | | | |
| Severe reaction to a vaccine before? | | | |
| Tendency to faint with injections? | | | |
| Recent chemotherapy/Radiotherapy/organ transplant? | | | |
| **Women only** | | | |
| Are you pregnant? | | | |
| Are you breast feeding? | | | |
| Are you planning a pregnancy while away? | | | |

For Admin Use Only:

Date Received: Date Reviewed: Date of Appointment:

## ONCE COMPLETING THIS FORM, PLEASE CONTACT THE SURGERY AFTER ONE WEEK

| **Are you currently taking any medication** (including prescribed, purchased or a contraception pill)? |
|---|
| |

| **Please supply any information on any vaccines or malaria tablets taken in the past** | | | | | |
|---|---|---|---|---|---|
| ☐ | Tetanus/polio/diphtheria | Date: | ☐ | Hepatitis A | Date: |
| ☐ | Typhoid | Date: | ☐ | Hepatitis B | Date: |
| ☐ | Cholera | Date: | ☐ | Japanese Encephalitis | Date: |
| ☐ | Rabies | Date: | ☐ | BCG | Date: |
| ☐ | Yellow fever | Date: | ☐ | Influenza | Date: |
| ☐ | Malaria tablets | Date: | ☐ | Pneumococcal | Date: |
| ☐ | MMR | Date: | ☐ | Meningitis | Date: |
| ☐ | Tick Borne Encephalitis | Date: | ☐ | Other (please give details below) | Date: |

| **Any additional information** | |
|---|---|
| | |
| Please return completed form to : | The Jacey Practice - **6 weeks** before travel |
| Email: | jaceypractice@nhs.net |
| Fax: | 0121 7336892 |

**You will be contacted if an appointment is necessary**

## FOR THE NURSE TO COMPLETE ONLY

| ***Vaccinations needed:*** | ***Completed / date:*** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |