



**PATIENT QUESTIONNAIRE  
PRIVATE & CONFIDENTIAL**


Please complete this side of the form before you see the nurse.

Please note **ONE** form **per** traveller

**Name:**

**Address:**

**Date of Birth:**



Departure Date

Duration of stay abroad

Which Countries do you intend to visit (including brief stopovers)

✓	TYPE OF HOLIDAY ACCOMMODATION	
	<b>HOTEL</b>	Clean accommodation in a town (urban stay)
	<b>SAFARI</b>	Hotel accommodation with trips into the country
	<b>CRUISE</b>	
	<b>BACKPACKER</b>	Prolonged overland travel or camping

Are you allergic to anything?  
(e.g. Egg, Gelatin, Rubber/Latex, Antibiotics, Antimalarial Products etc.)

Are you on any medications?

**Remember:** If you are receiving any medication, make sure that you take enough supplies to last through your overseas visit.

Have you ever had or are you suffering from heart disease or other chronic illness?

**There will be a charge for the following vaccinations: We accept payment by cash or debit/credit card.**

**Please Note we will ask you to pay at each consultation per vaccine or in full if preferred at the first consultation.**

HEPATITIS B	£35 per injection
JAPANESE B ENCEPHALITIS	£75 for each injection (course of 2)
TICK BOURNE ENCEPHALITIS	£55 for each injection (course of 2)
RABIES	£50 for each injection (course of 3)
YELLOW FEVER	£60.00
YELLOW FEVER Duplicate Cert.	£10.50
MENIVO	£55 per injection

Note: These charges may change without notice. Contact the surgery for the latest prices.

**THIS SIDE FOR PRACTICE USE ONLY**

**VACCINATION FITNESS CHECK LIST** ✓

1	Any current febrile illness		<b>YELLOW FEVER CHECK LIST</b>
2	Any chronic illness (e.g. epilepsy)		<b>CONSENT SIGNED</b>
3	Immunosuppressed eg. Steroid/Drugs		<b>CERTIFICATE GIVEN</b>
4	Cancer Therapy		<b>FEE OF £55.00 PAID AND RECEIPT GIVEN</b>
5	Any risk of Pregnancy		<b>REMEMBER TO TELL PATIENT THAT IT IS 10 DAYS BEFORE CERTIFICATE IS VALID</b>
6	Over 60 years & needs Y.Fever		<b>CHECK LAST VACCINE GIVEN UNDER 10 YEARS</b>
7	Thymus Disease or Thymectomy		<b>Batch Number:</b>
8	Any Live Vaccines in the last 4 weeks		
9	Splenectomy		<b>JAP B CHECKLIST</b>
10	Any Skin diseases (e.g. psoriasis)		<b>NAMED PATIENT FORM SIGNED</b>
11	Heart Disease		<b>FEE OF £50 PER INJECTION PAID</b>
12	BCG in last 12 weeks(if so avoid arm)		<b>10 DAYS BEFORE TRAVEL CONFIRMED</b>

VACCINATIONS REQUIRED	Ring required vaccinations									
VACCINE	PROGRAMME					DATE				
<b>LOW DOSE DIPHTHERIA TETANUS &amp; POLIO</b>	1	2	3	Booster	Booster					
<b>INACTIVATED POLIO</b>	1	2	3	Booster	Booster					
<b>HEPATYRIX</b>	1				Booster					
<b>HEPATITIS A</b>	1				Booster					
<b>HEPATITIS A JUNIOR</b>	1				Booster					
<b>TYPHOID</b>	1				Booster					
<b>HEPATITIS B</b>	1	2	3		Booster					
<b>YELLOW FEVER</b>	1				Booster					
<b>RABIES</b>	1	2	3		Booster					
<b>ENCEPHALITIS Jap B</b>	1	2	3		Booster					
<b>ENCEPHALITIS tick borne</b>	1	2								
<b>ACWY VAX</b>	1									
<b>TWINRIX</b>	1	2	3		Booster					
<b>AMBIRIX</b>	1	2								

**Initial**

**PATIENT CONSENT**

*I have received and understood the advice given to me concerning:-*

- |  |   |
|--|---|
| <input type="checkbox"/> <i>Myself / My Child</i>                | <input type="checkbox"/> <i>Antimalarial prophylaxis</i>      |
| <input type="checkbox"/> <i>Travel Vaccinations requirements</i> | <input type="checkbox"/> <i>General preventative measures</i> |

***I understand that there may be a Charge levied on certain vaccines and consent to the administration of the vaccines identified above***

***I accept that it is essential that I let you know if I am, or think I may be, HIV positive.***

**Signed:**

**Date:**