The Wellington Practice

TRAVEL RISK ASSESSMENT QUESTIONNA

PLEASE FULLY COMPLETE THIS SIDE

NAME ______________________________ DOB ____________ GP ______________

PHONE NUMBER/S ____________________________ EMAIL __________________________

***** TRAVEL FORM MUST BE SUBMITTED *AT LEAST 4 WEEKS* BEFORE TRAVEL *****

PLEASE LIST *ALL* TRAVEL PLANS, STATE *ALL* COUNTRIES (NOT CONTINENTS) INCLUDING

DATE OF TRAVEL	COUNTRY	LENGTH OF STAY	REMOTE?
1			Y / N
2			Y / N

TYPE OF TRAVEL / ACTIVITIES PLANNED (CIRCLE AS APPROPRIATE)

REASON FOR TRAVEL	HOLIDAY	WORK	GAP YEAR / EXPLORING	FRIENDS AND FAMILY
ACCOMMODATION	HOTEL	HOSTEL / BACKPACKING	CAMPING / TREKKING	CRUISE

MEDICAL HISTORY - PLEASE COMPLETE AND PROVIDE INFORMATION AS

		✓
ALLERGIES		
ADVERSE REACTION TO VACCINES		
PREGNANT / PLANNING PREGNANCY		
CHRONIC DISEASE (ASTHMA / DIABETES ETC)		
STEROIDS / IMMUNE SUPPRESSANT MEDS		
EPILEPSY / FAMILY HISTORY OF EPILEPSY		
MENTAL HEALTH DISORDERS		
CANCER / RADIOTHERAPY / CHEMOTHERAPY		
SPLENECTOMY / IMMUNE DISORDERS		
HIV +VE / HEP B / HEP C		

VACCINATION HISTORY – PLEASE PROVIDE DATES IF KNOWN

TETANUS / DIPTHERIA / POLIO		HEPATITIS A	
TYPHOID		HEPATITIS B	
RABIES		YELLOW FEVER	
JAP B ENCEPHALITIS		MENINGITIS ACWY	
TICKBORNE ENCEPHALITIS		MMR	

I have completed this form correctly and will inform you of any changes at my travel appointment

Signed: Patient / Parent / Guardian Date:

PLEASE BRING ALL VACCINE RECORDS TO YOUR TRAVEL APPOINTMENT
Some vaccines incur a charge, details available at reception, cash / cheque only please