**[ST PAUL'S PARTNERSHIP LYNG MEDICAL](https://www.stpaulslyngmedical.nhs.uk/)**

**Frank Fisher Way**

**West Bromwich**

**Birmingham**

**B70 7AW**

**Tel: 0121 612 2300**

**TRAVEL VACCINATION QUESTIONNAIRE**

**Date…………………………………**

|  |
| --- |
| **Personal details** |
| **NAME:** | **D.O.B Male / Female / other** |
| **ADDRESS:** | **Contact Number:** |

 **Please circle.**

|  |  |  |  |
| --- | --- | --- | --- |
| **COUNTRY TO BE VISTED** | **DATE OF TRAVEL:** | **RETURN DATE:** | **PURPOSE OF TRAVEL eg**  |
| **1.** |  |  | **Safari- back packing** |
| **2.** |  |  | **Pilgrim -adventure**  |
| **3.** |  |  | **Staying in hostel**  |
| **4.** |  |  | **Other** |

**Please circle.**

|  |  |  |
| --- | --- | --- |
| **REASON FOR TRAVEL**  | **Holiday?** | **work?** |
| **ALLERGIES (Please state if any):** |
| **ARE YOU PREGNANT OR MIGHT BE BEFORE TRAVEL? YES - NO** |
| **PREVIOUS INJ- (Please state if you have had any previous adverse reactions)** |

**(If you have received vaccines elsewhere which will not be in our clinical records, please provide details below)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **YES** | **NO** | **DATE** | **INJ REQUIRED**  |
| **TYPHOID** |  |  |  |  |
| **HEPATITIS A** |  |  |  |  |
| **HEPATITUS B** |  |  |  |  |
| **TETNUS** |  |  |  |  |
| **POLIO** |  |  |  |  |
| **YELLOW FEVER** |  |  |  |  |
| **TUBERCULOSIS (BCG)** |  |  |  |  |
| **MENINGITIS** |  |  |  |  |
| **OTHER**  |  |  |  |  |

**Smoking Status - Smoker Yes / No Ex-Smoker Yes/ No Never Smoked Yes / No**

**Travel vaccines clinic appointments are subject to availability.**

**Many Pharmacies also offer travel vaccines services and advice, please enquire with reception team for further details.**

**PRACTICE REQUIRES minimum 6 Weeks’ NOTICE TO ADMINISTRATE TRAVEL VACCINES IF REQUIRED.**

**We do not give yellow fever injections or prescription for Malaria medication, please see your pharmacist.**

**Please complete this form and return to the receptionist.**

**Checked by ………………………………………………Date ………………………………**

 **Date Patient contacted ………………………... Staff Members initials ………………………….**