

Please complete this form and return to the Surgery as soon as possible.
 You may telephone for instructions on 01904 724400 after 2 working days.

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

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 :			
Chloroquine			
Proguanil			
Malarone			
Mefloquine			
Doxycycline			

TRAVEL ADVICE GIVEN	YES/NO
----------------------------	---------------