MEADOWSIDE MEDICAL CENTRE

TRAVEL VACCINATION QUESTIONNAIRE

Please complete this form and return it to the receptionist.
The Practice Nurse or receptionist will contact you by phone to discuss your vaccination requirements and arrange an appointment for you to attend our travel clinic. Please use the reverse side of the form if you need to.

NAME	***DATE OF BIRTH***
ADDRESS	**TEL** **MOBILE**

DESTINATIONS – COUNTRY AND RESORT (Include any stopovers on the journey)

REASON FOR TRAVEL *Holiday / Work*	***LENGTH OF STAY***
DATE OF TRAVEL	***TYPE OF ACCOMODATION*** (e.g. hotel, self catering, camping, backpacking, etc)

PLEASE LIST ANY known **ALLERGIES**

Female Patients only: Are you **pregnant** or might you be before you travel? Yes / No

PREVIOUS INJECTIONS If Known (Please state if you have had any previous adverse reactions)

INJECTION	Yes / No	Date	INJECTION	Yes / No	Date
Tetanus			Hepatitis A		
Polio			Hepatitis B		
Rabies			Cholera		
Yellow fever			Meningitis A/C		
Tuberculosis			Malaria		
Typhoid					

Patient signature	Date	Continue on reverse

Please add any additional relevant information below:

FOR PRACTICE NURSE USE

RECOMMENDED VACCINATIONS:

NOTES: