

Saville Travel Clinic Pre-Travel Questionnaire

Office only, scan and shred ☐

Appointment date and time: _____

Name: _____ DOB: _____ Male ☐ Female ☐
Address: _____ Postcode: _____
Tel no: _____

Type of travel: Holiday ☐ Business ☐ Elective Dentistry ☐ Medicine ☐ Volunteer ☐ (please tick one box)

Departure Date: _____

Return Date: _____

Previous / Current health problems: _____

I will be visiting the following Countries and length of stay

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Accommodation Type

Star Rating

High risk activities: _____

Are you allergic to or have you reacted badly to medicines, antibiotics, eggs, or previous vaccines? Y ☐ / N ☐

Details: _____

List any current /repeat medication: _____

| |
|-------|
| _____ |
| _____ |

THIS BOX IS FOR PRACTICE USE ONLY

| APPT DATE | TIME & NURSE | VACC | PAID |
|-----------|--------------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

THIS BOX FOR PRACTICE USE ONLY

| | | | | |
|----------------------------------|------------------|-------|-------|-------|
| Rabies (x3 injections) | £55.00 (per jab) | _____ | _____ | _____ |
| Yellow Fever | £55.00 | _____ | _____ | _____ |
| Jap Encephalitis (x2 injections) | £85.00 (per jab) | _____ | _____ | _____ |
| Meningitis ACWY | £55.00 | _____ | _____ | _____ |
| Prescription | £12.00 | _____ | _____ | _____ |

Women only:

Last Menstrual Period _____

Are you pregnant, planning a pregnancy or breast feeding? Y ☐ N ☐

All travellers:

I have received information on the risks and the benefits of the vaccines recommended and have had the opportunity to ask questions.
I consent to the vaccines being given.

Signed.....

Date.....

- Operations on Thymus gland? Y ☐ / N ☐
- Do you have Psoriasis? Y ☐ / N ☐
- Do you have cardiac problems? Y ☐ / N ☐
- Do you have epilepsy/convulsions? Y ☐ / N ☐
- Have you ever suffered from anxiety / depression? Y ☐ / N ☐

- Have you any family members who have ever suffered from anxiety / depression? Y ☐ / N ☐
- Are you well today? Y ☐ / N ☐

Have you had any recent treatment (chemotherapy, oral steroids, radiation) or do you suffer from a condition that may suppress your immune system (Lymphoma, Leukemia, Hodgkin's disease, HIV)

Y ☐ / N ☐

