**JAMES FISHER MEDICAL CENTRE**

**PATIENT QUESTIONNAIRE FOR HOLIDAY AND TRAVEL**

**This form must be completed by the person named below unless they are under 16**

**Name………………………………………… Address…………………………………………………………….**

**Date of Birth……………………………… …………………………………………………………………………**

**Telephone Number…………………… …………………………………………………………………………**

**Mobile Number………………………… E mail……………………………………………………………….**

Please tick box if we may phone you if you do not require any vaccinations □

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| You may need travel vaccinations and health advice, depending on where you are visiting. To help us advise you on the protection you may need please return this form completed at least 8 weeks before departure date, **if within 8 weeks we may be unable to provide all appointments required for your Travel Vaccinations, and therefore may need to attend a local private clinic and pay their fees.**  Each traveller will need to book a 20 minute appointment.  ***This form when completed must be returned to the surgery at least two weeks prior to your appointment. Patients bringing in this form less than 2 weeks before their appointment will be asked to rebook.***  **Please note charges may be made for certain vaccinations and payment is required at time appointment. We are only able to accept cash or cheques.** | | | | | | |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW** | | | | | | |
| **Date of departure:** | | **Total length of trip:** | | | | |
| **COUNTRY TO BE VISITED** | **EXACT LOCATION OR REGION** | **CITY OR RURAL** | | | | **LENGTH OF STAY** |
| **1.** |  |  | | | |  |
| **2.** |  |  | | | |  |
| **3.** |  |  | | | |  |
| Have you taken out travel insurance for this trip?  Do you plan to travel abroad again in the future? | | | | | | |
| **It is imperative that full details of your proposed travel to be given, otherwise you may be putting your self at risk of illness and your travel insurance may be invalid.** | | | | | | |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY** | | | | | | |
| **□ Holiday □ Staying in hotel □ Backpacking □ Business trip**  **□ Cruise ship trip □ Camping/Hostel □ Expatriate □ Safari**    **□ Adventure □ Volunteer work □ Pilgrimage □ Diving**  **□ Healthcare worker □ Medical tourism □ Visiting friends/family** | | | | | | |
| **PLEASE SUPPPY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | | | | |
|  | | | **YES** | **NO** | **DETAILS** | |
| Are you fit and well today | | |  |  |  | |
| Any allergies including food, latex, medication, gelatine | | |  |  |  | |
| Severe reaction to a vaccine before | | |  |  |  | |
| Tendency to faint with injections | | |  |  |  | |
| Any surgical operations in the past, including e.g. your spleen or thymus gland removed | | |  |  |  | |
| Recent chemotherapy/radiotherapy/organ transplant | | |  |  |  | |
| Anaemia | | |  |  |  | |
| Bleeding/clotting disorders (including history of DVT) | | |  |  |  | |
| Heart disease (e.g. angina, high blood pressure) | | |  |  |  | |
| Diabetes | | |  |  |  | |
| Epilepsy/ seizures | | |  |  |  | |
| Gastrointestinal (stomach) complaints | | |  |  |  | |
| Liver and or kidney problems | | |  |  |  | |
| HIV/AIDS | | |  |  |  | |
| Immune system condition | | |  |  |  | |
| Mental health issues (including anxiety, depression) | | |  |  |  | |
| Neurological (nervous system) illness | | |  |  |  | |
| Respiratory (lung) disease | | |  |  |  | |
| Rheumatology (joint) conditions | | |  |  |  | |
| Spleen problems | | |  |  |  | |
| Any other conditions? | | |  |  |  | |
| **Women only** | | |  |  |  | |
| Are your pregnant? | | |  |  |  | |
| Are you breast feeding? | | |  |  |  | |
| Are you planning pregnancy while away | | |  |  |  | |

|  |
| --- |
| **Are you currently taking any medication** (including prescribed, purchased or contraceptive pill)? |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** | | | | | |
| **Tetanus/polio/diphtheria** |  | **MMR** |  | **Influenza** |  |
| **Typhoid** |  | **Hepatitis A** |  | **Pneumococcal** |  |
| **Cholera** |  | **Hepatitis B** |  | **Meningitis** |  |
| **Rabies** |  | **Japenese Encephalitis** |  | **Tick Borne Encephalitis** |  |
| **Yellow fever** |  | **BCG** |  | **Other** |  |
| **Malaria Tablets** | | | | | |
| Any additional information | | | | | |

**TRAVEL VACCINE PRICE LIST**

**For chargeable vaccinations payment is required prior to being given the vaccine, Cash or Cheque (Cheques will only be accepted for amounts of £15.00 or above and should be made payable to ‘James Fisher Medical Centre’)**

**HEPATITIS A - Free**

**TYPHOID - Free**

**HEPATITIS & TYPHOID Combined – Free**

**CHOLERA - Prescription will be issued and normal prescription fees will apply**

**HEPATITIS B**

Routine Course (3 doses over 6 months) - £85.00 (or £40 single dose)

Accelerated Course (4 doses over 12 months) - £110 (or £40 single dose)

**\* We only provide Hepatitis B Vaccinations for travel purposes, we do not provide these vaccinations for occupational purposes.**

**MALARIA PROPHYLAXIS**

Private Prescription - £10 (prior to purchasing preferred choice at a pharmacy)

Please feel free to look at the ‘Fit for Travel’ website prior to you travel appointment for information and recommended vaccinations

All vaccines can be accessed via a private travel clinic. They will have their own price list including those vaccines that we offer at the surgery and others that we do not supply.