

## The Harvey Practice – Holiday Health Questionnaire

Name:		Date of birth:	
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Telephone number(s):	Email:

### Dates you are travelling:

Departure date:	Return date:
(If return date not known, please give the approximate length of trip):	

### Countries to be visited:

Country	Length of Stay	Approx distance to nearest medical help

### Please tick all boxes which are relevant to your trip

Type of trip	Business	<input type="checkbox"/>	Pleasure	<input type="checkbox"/>	Other	<input type="checkbox"/>
Type of holiday	Adventure	<input type="checkbox"/>	Safari	<input type="checkbox"/>	Skiing	<input type="checkbox"/>
	Package	<input type="checkbox"/>	Cruise Ship	<input type="checkbox"/>	Camping	<input type="checkbox"/>
	Trekking	<input type="checkbox"/>	Back packing	<input type="checkbox"/>	Other	<input type="checkbox"/>
Accommodation	Hotel	<input type="checkbox"/>	Friends / Family	<input type="checkbox"/>	Other	<input type="checkbox"/>
Travelling	With family	<input type="checkbox"/>	In a group	<input type="checkbox"/>	Alone	<input type="checkbox"/>
Is the area you are staying	Rural	<input type="checkbox"/>	Urban	<input type="checkbox"/>	Mountainous	<input type="checkbox"/>

### Your medical history

Please give details of any current or past medical history which may be considered relevant (such as diabetes, heart or lung conditions). Please list current or repeat medications.

Do you have any allergies (eggs, nuts, antibiotics etc)?

Do you have any history of mental illness (including depression or anxiety)?

Do you have any history of radiotherapy, chemotherapy or steroid treatment?

Have you ever experienced a serious reaction to a vaccine given to you in the past?

Do you, or any close family members, suffer from epilepsy?

**Women only** – Are you pregnant, breast feeding or planning pregnancy?

Have you applied for travel insurance and advised the insurers of any medical conditions?

Vaccination history					
If you have ever had any of the following vaccinations / malaria tablets, please give the date.					
Tetanus		Diphtheria		Polio	
Hepatitis A		Hepatitis B		Typhoid	
Meningitis		Yellow Fever		Influenza	
Tick Borne		Rabies		Jap B Enceph	
Malaria tablets			Other		

Please give any additional information you consider relevant on the reverse of this form.

The answers you have given will be discussed during your appointment. At that time, you will be asked to sign the following declaration:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the recommended vaccines and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

OFFICE USE ONLY					
Patient Name:					
Travel risk assessment performed ? Yes [ ] No [ ]					
Vaccines recommended for this trip					
Disease	Yes	No	Comments		
Tetanus					
Diphtheria					
Polio					
Hepatitis A					
Hepatitis B					
Typhoid					
Meningitis ACWY					
Yellow Fever					
Rabies					
Jap B Enceph					
Cholera					
Other					
Leaflets & advice given					
Food water and personal hygiene advice		Travellers' diarrhoea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun & heat protection	
Web sites	Travel Record card supplied				
	Other				
Malaria prevention advice and malaria chemoprophylaxis					
Chloroquine & proguanil		Atovaquone & proguanil (Malarone)			
Chloroquine		Mefloquine			
Doxycycline		Malaria advice leaflet given			
Further information (continue overleaf if necessary)					
				Signed by:	