**Health Professionals:** Local guidance for record keeping should be followed. The Yellow Fever checklist for travellers should be used for Yellow Fever risk assessment.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TRAVEL DETAILS**

**Departure Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of trip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Return Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Country** | **Destination within the country** | **Length of stay** | **Mode of transport** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Destination description – Please tick all that apply**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Urban (Town/City)** |  | **Rural**  |  | **Jungle** |  | **Desert** |  |
| **Coastal** |  | **High altitude** |  | **Safari** |  | **Other** |  |

**Purpose of the trip – Please tick all that apply**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Adventure** |  | **Aid work** |  | **Business** |  | **Charity** |  |
| **Cruise** |  | **Diving** |  | **Health Worker** |  | **Holiday** |  |
| **Long term** |  | **Medical Treatment** |  | **Pilgrimage** |  | **Visiting**  |  |

**Accomodation – Please tick all that apply**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Hotel** |  | **Hostel** |  | **Camping** |  | **Family/Friends** |  |
| **Other** |  |

**Do you have travel health insurance? Covering any pre-existing health condition and planned activities if relevant?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes** |  | **No** |  |

**MEDICAL HISTORY**

Please tick either ‘Yes’ OR ‘No’. If you answer ‘Yes’ to any of the questions, please provide details below.

|  |  |  |
| --- | --- | --- |
| **QUESTION** | **YES** | **NO** |
| Are you well today? |  |  |
| Do you have any health conditions? E.G. Diabetes, Respiratory problems, Heart disease, Neurological illness, Liver or Kidney problems, Blood disorders (Sickle Cell Disease, Clotting or Bleeding issue) |  |  |
| Do you, or a first degree relative (Parent, Sibling or Child) have Epilepsy or seizures? |  |  |
| Have you, or a first degree relative (Parent, Sibling or Child) ever experienced any mental health issues, even mild anxiety or depression? |  |  |
| Do you have, or have you had, a condition that could impair your immune system? E.G. HIV/AIDS, Blood cancer |  |  |
| In the last 12 months, have you taken a medication or had treatment that could impair your immune system? E.G. Chemotherapy, Radiotherapy, High dose steroids. |  |  |
| Have you ever had surgery? E.G. Open-heart surgery, Transplant surgery, Spleen or Thymus gland removal. |  |  |
| Have you ever had a travel related illness/injury that required assessment/treatment in hospital? |  |  |
| Are you receiving regular treatment or having regular follow ups with your GP / Hospital consultant? |  |  |
| Do you have any disability or mobility problems? |  |  |
| Do you have any allergies? E.G. Food, medication or latex |  |  |
| Have you, or anyone in your family, ever had a severe reaction to a vaccine or Malaria medication? |  |  |
| Are you or your partner pregnant or planning a pregnancy? |  |  |
| Are you breastfeeding? |  |  |
| **FURTHER DETAILS**If you answered ‘Yes’ to any of the questions above, please provide details here with any other important information regarding your health, including problems experienced with previous travel: |  |  |

**MEDICATION**

Please give details of any medication you are taking, including prescribed/self-treatment/over-the-counter remedies and contraception.

|  |  |
| --- | --- |
| **Name of medication** | **Dose/Frequency** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Babies and Children ONLY**

**Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VACCINE HISTORY**

If you have received vaccinations elsewhere which will not be in our clinic records, please provide details.

|  |  |  |
| --- | --- | --- |
|  | **Date of vaccine**  | **Notes** |
| BCG |  |  |
| Cholera |  |  |
| COVID-19 |  |  |
| Diphtheria/Tetanus/Polio |  |  |
| Hepatitis A |  |  |
| Hepatitis A/B |  |  |
| Hepatitis B |  |  |
| Japanese Encephalitis |  |  |
| Influenza (Flu) |  |  |
| Meningitis ACWY |  |  |
| MMR |  |  |
| Rabies |  |  |
| Tick-borne Encephalitis |  |  |
| Typhoid |  |  |
| Yellow Fever |  |  |

**HEALTH PROFESSIONAL USE ONLY**

|  |  |  |
| --- | --- | --- |
| **Risk management**  | **Discussed** | **Comments** |
| Medical preparation (Including pre-existing conditions) |  |  |
| Journey risks |  |  |
| Personal safety/Accidents/Injuries |  |  |
| Environmental risks |  |  |
| Food and water safety |  |  |
| Vector-borne risks |  |  |
| Malaria ABCD (record medication) |  |  |
| Rabies and animal bite |  |  |
| Sexual health and blood-borne viruses |  |  |
| Skin/Sun health |  |  |
| Psychological health |  |  |
| FGM |  |  |

**VACCINATIONS DISCUSSED TODAY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | A | D | G |  | A | D | G |
| Cholera |  |  |  | MMR |  |  |  |
| Diphtheria/Tetanus/Polio |  |  |  | Rabies |  |  |  |
| Hepatitis A |  |  |  | Typhoid |  |  |  |
| Hepatitis B |  |  |  | Yellow Fever |  |  |  |
| Japanese Encephalitis |  |  |  | Influenza |  |  |  |
| Meningitis ACWY |  |  |  | Tick-borne Encephalitis  |  |  |  |
| Childhood UK vaccination programme up to date? | **YES** | **NO** |  |

**ANTIMALARIAL MEDICATION DISCUSSED TODAY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Recommended** | **Prescribed?** | **Declined** | **Referred** |
| Atovaquone & Proguanil |  |  |  |  |
| Chloroquine & Proguanil |  |  |  |  |
| Doxycycline |  |  |  |  |
| Mefloquine |  |  |  |  |
| Emergency standby |  |  |  |  |
| **Any other advice or comments?** |
| **Source of information used to advise traveller? E.G. TravelHealthPro** |

**\*Local guidelines for record keeping should be followed\***

**Name of health professional (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of health professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**