DATE FORM RECEIVED –	
RECEPTIONIST INITIALS –	

HOLIDAY VACCINATION REQUEST

Dear Patient

In order for us to advise you about recommended vaccinations for your trip abroad, you must complete this form with as much detail as possible.

Please complete this form at least 6 WEEKS before your departure date. 1 form is required for each patient registered with the practice.

Make an appointment with the Practice Nurse for each member of a family for a travel health assessment. Please note, we only provide basic advice, if your travel is complex you may be asked to attend a private clinic, which will incur a fee.

Please bring your completed form to your appointment. Any prescriptions required will be issued and a further appointment given for administration.

If necessary the travel clinic details are –

Yellow Fever - Make appointment at Muirside Practice
0141 531 8040

Contact Private Travel Clinic

Lloyds	www.lloydspharmacy.com	020 7318 2412
Boots (Glasgow Fort)		0141 773 4817
Brownlee Gartnavel Travel Clinic		open Wednesday mornings, 9.30 - 12.30 Contact: Tel: 0141 211 1074

I have read and understand the above.

Signed: _____ Date: _____

Travel Questionnaire

Personal Details

Name: _____ Sex: Female ○ Male ○

Date of Birth: _____ Address _____

Daytime Tel: _____

Email: _____

Trip Dates

Departure: _____ Duration: _____

Itinerary

Country = **EXACT DESTINATION / RESORT**	Duration	Availability of Medical Help ***(i)***

Trip Description - please tick all appropriate boxes:

Purpose of Trip: ☐ Business ☐ Pleasure ☐ Other

Type of Trip: ☐ Package ☐ Self-Organised ☐ Backpacking ☐ Camping ☐ Cruise Ship ☐ Trekking

Accommodation: ☐ Hotel ☐ Friends/Family ☐ Other

Travelling: ☐ Alone ☐ With Friend/Family ☐ In a Group

Location Type: ☐ Urban ☐ Rural ☐ Altitude***(i)***

Activity Type: ☐ Safari ☐ Adventure ☐ Other

Personal Medical History

List all chronic medical conditions that you have (eg. diabetes, heart or lung conditions)

List all allergies that you have (eg. eggs, nuts, antibiotics)

If you have had a serious reaction to a vaccine in the past, which vaccine was it?

List all of your current medications (including oral contraception)

Have you recently suffered from any infection (e.g heavy cold, flu or high temperature)? ☐ Yes

Does having an injection cause you to feel faint? ☐ Yes

Do you or any close family members have epilepsy? ☐ Yes

Do you have any history of mental illness including depression or anxiety? ☐ Yes

Have you recently undergone radiotherapy, chemotherapy or steroid treatment? ☐ Yes

Have you taken out travel insurance? ☐ Yes

If you have a medical condition, have you told your insurance company about it? ☐ Yes

Are you pregnant, planning pregnancy or breast feeding? ☐ Yes

Write below any further information that might be relevant

Vaccination History

Have you ever had any of the following vaccinations / tablets and if so, when?

Tetanus	☐ Yes		Polio	☐ Yes	
Diphtheria	☐ Yes		Typhoid	☐ Yes	
Hepatitis A	☐ Yes		Hepatitis B	☐ Yes	
Meningitis	☐ Yes		Yellow Fever	☐ Yes	
Influenza	☐ Yes		Rabies	☐ Yes	
Jap B Enceph	☐ Yes		Tick Borne	☐ Yes	
Malaria Tablets	☐ Yes		Other		