

# Travel Consultation Record

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: m/f

<b>Travel Itinerary</b>	
Date of Departure _____	
Destination(s) and duration of stay _____ _____ _____	
<b>Type of holiday</b>	
Holiday/Business/VFR/Other details _____	
<b>Accommodation</b>	
Hotel ____ Star / Hostel / Family home etc _____	
High Risk Activities (eg. Winter sports, safari, climbing, water sports etc) _____ _____ _____	

<b>Previous/Current Medical History</b> (e.g. asthma, diabetes, epilepsy, asplenic)	
_____ _____ _____ _____ _____	
Allergies to any drugs or Food _____ _____	
Steroids:	Y/N    Contraceptive Pill: Y/N/NA
Pregnant:	Y/N/NA    Pregnancy Planned: Y/N
Well today? _____ _____	
Medical Insurance Arranged?    Y/N	

<b>Previous Vaccination History</b>	
Previous Reaction to any vaccines	Y/N
Feels Faint with Injection	Y/N
Vaccination	Date rcvd
Tetanus	
Diphtheria	
Polio	
Typhoid	
Hepatitis A 1 <sup>st</sup> or Bst	
Hepatitis B 1 <sup>st</sup> 2 <sup>nd</sup> 3 <sup>rd</sup> 4th	
Meningitis	
Yellow Fever	
Other	

Recommended Vaccines	
Tetanus/diphtheria	
Polio	
Typhoid	
Hepatitis A	
Hepatitis B	
Meningitis A/C	
Yellow Fever	
Other	

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

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