

Burnham Health Centre
PRE-TRAVEL HEALTH & VACCINATION
ASSESSMENT

Surname.....
Forename.....
Telephone Number.....
Date of Birth.....
M/F.....

1. What is your departure date?
.....
2. How long will you be
away?.....
3. Which countries do you intend to
visit? (including brief
stopovers).....
.....
.....
4. Will your journey take you to the:
coast.....
interior.....
islands.....
5. Will you be staying in:
tourist hotels.....
relatives' homes.....
local accommodation.....
6. Are you travelling with:
family.....
partner.....
alone.....
group.....

7. Are you going on:
an organised package tour.....
organising it yourself.....
taking a backpacking holiday.....
8. Is your holiday for:
pleasure.....
business.....
for a period of voluntary service in a
remote area.....
9. Will you be going on safari,
travelling in areas with poor
communication or participating in
adventure sports
Yes No If yes please give
details.....
.....
10. Will you be in areas where medical
help is non-existent (even for a short
period)
Yes No If yes please give
details.....
.....
11. Are you suffering from any minor
ailments?
Yes No If yes please give details
.....
.....

12. Do you have any long-term medical conditions?

Yes No If yes please give details

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13. Do you have a history of epilepsy?

Yes No If yes please give details

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14. Have you ever experienced anxiety, depression or other psychological problems which have required treatment?

Yes No If yes please give details

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15. Have you had your spleen removed?

Yes No If yes please give details

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16. Have you ever had a bad reaction to a vaccine?

Yes No If yes please give details

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17. Do you have any other allergies, e.g. eggs?

Yes No If yes please give details

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18. Are you taking any medication including the oral contraception pill, or have you been on antibiotics within the last 10 days?

Yes No If yes please give details

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19. Are you pregnant, breast feeding or planning a pregnancy?

Yes No If yes please give details

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20. Are you HIV positive?

Yes No If yes please give details

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21. Have you recently received treatment with radiotherapy, chemotherapy or steroids?

Yes No If yes please give details

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22. Are any children who are travelling up to date with their childhood vaccinations?

Yes No If yes please give details

23. Have you previously had any vaccinations?

Yes No

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24. Have you had any of the following vaccinations and, if so, when?

Typhoid..... Meningitis.....

Tetanus..... Rabies.....

Polio..... Yellow Fever...

Hepatitis A..... Hepatitis B.....

Diphtheria..... BCG.....

Japanese Encephalitis.....

Tick-borne Encephalitis.....