North Ringwood Medical Centre
Pre-Travel Assessment Form

Please complete prior to your consultation

Patient Details:

Title	First Name	Surname	D.O.B.	Sex	Country of Passport
				M / F	

General Practitioner's contact details:		Your occupation:	
		This trip is for:	☐ Business
			☐ Leisure

Medical Background:	✓	
Do you have any significant health problems	☐Yes	☐No
Have you ever fainted or felt unwell soon after an injection?	☐Yes	☐No
(Females only) Could you be pregnant now or while away?	☐Yes	☐No
Does someone with lowered immunity live at home with you?	☐Yes	☐No
Are you allergic to eggs, medications or other substances?	☐Yes	☐No
Please list all medications you are currently taking:		
Please list significant medical / health problems you have had (travel related or otherwise):		

Vaccination Background:

Vaccine	Year	Vaccine	Year	Vaccine	Year
Tetanus / Diphtheria / Whooping cough		Measles / Mumps / Rubella		Mantoux / BCG	
Polio		Hepatitis B		Meningococcal	
Influenza (flu)				Japanese Encephalitis	
Pneumonia		Hepatitis A		Q fever	
Cervical cancer vaccine		Typhoid		Rabies	
Varicella (chicken pox)		Cholera		Yellow fever	

Travel Itinerary:

Departure date:		Return date:	

Country (in order of visit)	Region/City (if known)	Accommodation (hotel/tent/ other)	Duration (weeks)

Appointment Date:___/___/___ Time:_____