

NHS BORDERS TRAVEL HEALTH PATIENT QUESTIONNAIRE



Return form via e-mail to vaccination.bookinghub@borders.scot.nhs.uk

Return form via post to NHS Borders Vaccination Hub, 7 Tweedside Park, Tweedbank, Galashiels, TD1 3TE

Forms may also be handed in an envelope to the health board reception team in an NHS Borders health centre.

PERSONAL DETAILS			
Full name		Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of birth		Address	
Mobile telephone			
Home telephone			
GP practice		Emergency contact name & number	
E-mail address			

YOUR TRIP			
Total length of your trip			
Destination(s) <i>countries and specific places (areas, cities) including stopovers</i>	Arrival Date	Departure date	
1.			
2.			
3.			
4.			
5.			
TYPES(S) OF TRAVEL (Tick all that apply)	YES	ACTIVITIES (Tick all that apply)	YES
Holiday	<input type="checkbox"/>	Visiting friends/relatives	<input type="checkbox"/>
Cruise	<input type="checkbox"/>	Sports/adventure	<input type="checkbox"/>
Business	<input type="checkbox"/>	High risk, inc drug use, tattoos, unprotected sex	<input type="checkbox"/>
Backpacking	<input type="checkbox"/>	Altitude	<input type="checkbox"/>
Pilgrimage	<input type="checkbox"/>	Working with animals	<input type="checkbox"/>
Remote <small>away from medical access</small>	<input type="checkbox"/>	Healthcare work	<input type="checkbox"/>
Hotel	<input type="checkbox"/>	Medical tourism	<input type="checkbox"/>
Camping/hostels	<input type="checkbox"/>		
Safari	<input type="checkbox"/> Guided safari YES <input type="checkbox"/> NO <input type="checkbox"/>	Volunteer work	<input type="checkbox"/> Working with children/school YES <input type="checkbox"/> NO <input type="checkbox"/>
Any additional information about your trip?			

MEDICAL HISTORY		NO	YES	DETAILS
Have you ever had a severe allergic reaction or anaphylaxis in the past?		<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking any medication including prescribed, purchased, contraception, or having any regular treatment?		<input type="checkbox"/>	<input type="checkbox"/>	
Women only	Are you Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	
	Are you breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	
	Planning to be pregnant soon or whilst away	<input type="checkbox"/>	<input type="checkbox"/>	
Do you suffer from any diagnosed long term conditions we should be aware of including immunosuppression's?				

VACCINATION HISTORY	
<p>You <u>MUST PROVIDE</u> details and dates of all previous vaccinations, including childhood immunisations which may be provided on a separate sheet.</p> <p>You may need to contact your GP practice to request a copy of your vaccination history.</p>	
BCG/TB	
Cholera	
Diphtheria/ Tetanus/ Polio	
Hepatitis A	
Hepatitis B	
Japanese Encephalitis	
Meningitis ACWY	

MMR	
Rabies	
Tick Borne Encephalitis	
Typhoid	
Yellow Fever	
Pneumococcal	
Influenza	
COVID-19	
Any additional information	