Stopgate Lane Medical Centre
6 Stopgate Lane, Walton, Liverpool L9 6AP

Travel Health Questionnaire

Please complete this questionnaire as fully as you can before your travel appointment with the practice nurse, and bring it with you. It helps us understand your trip and your health so we can give you the right advice and recommend any vaccinations or anti-malaria tablets you may need.

Before you start

Book early — ideally 6–8 weeks before you travel. Some vaccines take time to work or are given as a course.

Travelling as a family? Please complete a separate form for each person.

1. Your details

Full name	
Date of birth	
Country of origin	
Sex	☐ Male ☐ Female ☐ Non-binary
Email	
Telephone (landline)	
Mobile number	

2. Your trip

Date of departure	
Total length of trip	
Modes of transport (e.g. plane, coach, car, boat)	
Travel insurance arranged for this trip?	☐ Yes ☐ No
Do you plan to travel abroad again in the future?	☐ Yes ☐ No

Places you will visit (list each destination, region, whether city or rural, and how long you will stay):

#	Country / region	City or rural?	Length of stay
1			
2			
3			
4			
5			

3. Type and purpose of trip

Please tick all that apply.

☐ Holiday	☐ Business	☐ Expatriate
☐ Volunteer work	☐ Healthcare work	☐ Visiting family / friends
☐ Staying in hotel	☐ Cruise ship	☐ Safari
☐ Pilgrimage	☐ Medical tourism	☐ Backpacking
☐ Camping / hostels	☐ Adventure	☐ Diving

Additional information

4. Your medical history

Please answer Yes or No to each. Add brief details where relevant — there is no need to write a lot.

	Yes	No	Details
Are you fit and well today?	☐	☐	
Any allergies (including food, latex or medication)?	☐	☐	
Have you, or anyone in your family, ever had a severe reaction to a vaccine or anti-malaria medication?	☐	☐	
Do you tend to faint with injections?	☐	☐	
Any surgical operations (e.g. heart surgery, removal of spleen or thymus gland)?	☐	☐	
Recent chemotherapy, radiotherapy or organ transplant?	☐	☐	
Anaemia?	☐	☐	
Bleeding or clotting disorder (including history of DVT)?	☐	☐	
Heart disease (e.g. angina, high blood pressure)?	☐	☐	
Diabetes?	☐	☐	
Any additional needs and/or disability?	☐	☐	
Epilepsy or seizures (including in a first-degree relative)?	☐	☐	
Gastrointestinal (stomach) complaints?	☐	☐	
Liver or kidney problems?	☐	☐	
HIV / AIDS?	☐	☐	
Immune system condition (e.g. blood cancer)?	☐	☐	
Mental health concerns (including anxiety or depression)?	☐	☐	
Neurological (nervous system) illness?	☐	☐	
Respiratory (lung) disease?	☐	☐	
Rheumatology (joint) conditions?	☐	☐	
Spleen problems?	☐	☐	
Any other medical conditions?	☐	☐	
Are you, or your partner, pregnant or planning a	☐	☐	

	Yes	No	Details
pregnancy?			
Are you breastfeeding (if applicable)?	☐	☐	
Have you, or anyone in your family, undergone FGM / been cut / circumcised?	☐	☐	
Are you currently taking any medication (prescribed, bought, or a contraceptive pill)?	☐	☐	

5. Vaccinations and malaria tablets you have had before

Tick any you have had, and add the year if you know it. Don't worry if you are unsure.

Vaccine	Year (if known)	Vaccine	Year (if known)
☐ Tetanus / Polio / Diphtheria		☐ MMR (measles, mumps, rubella)	
☐ Influenza (flu)		☐ Typhoid	
☐ Hepatitis A		☐ Pneumococcal	
☐ Cholera		☐ Hepatitis B	
☐ Meningitis		☐ Rabies	
☐ Japanese Encephalitis		☐ Tick-borne Encephalitis	
☐ Yellow Fever		☐ BCG (tuberculosis)	
Other (please specify)			

Thank you. Please bring this completed form to reception and we will arrange your appointment.

For practice use only — to be completed by the prescriber

Patient Specific Direction (PSD)

Following completion of the travel risk assessment, the vaccine(s) listed below may be administered to the named patient under this Patient Specific Direction. This direction is for a single named patient only.

Patient name		**Date of birth**	
NHS number		**Date of assessment**	

Vaccine(s) authorised

Vaccine / medicine (name, form & strength)	Dose, route & schedule	Start date	Finish date

Prescriber authorisation

I authorise administration of the above vaccine(s) to the named patient as a Patient Specific Direction.

Prescriber name (print)		**GMC / NMC number**	
Signature		**Date**	

To be completed by the administering clinician after vaccination

Vaccine administration record

Vaccine	Batch no.	Expiry	Dose / stage	Site	Date given	Given by (sign)

Please confirm:

☐ Vaccine details recorded on the patient computer record (name, batch no., stage, site)
☐ SMS or postcard vaccine reminder service set up (where a course is due)
☐ Travel record card supplied or updated

Consultation / administration performed by (name & signature)		**Date**	