**PATIENT TRAVEL VACCINATION QUESTIONNAIRE**

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| --- | --- |
| **Name**  |  |
| **Date of Birth** |  |
| **Contact telephone number** |  |

|  |  |
| --- | --- |
| **Departure date** |  |
| **Destination**If you are travelling to more than one destination, please give dates for each country |  |
| **Do you have travel insurance?** | Yes / No |

|  |  |
| --- | --- |
| **Are you pregnant?** | Yes / No |
| **Do you have any allergies?**If yes, please list | Yes / No |
| **Have you had a previous reaction to any vaccination?** | Yes / No |
| **Are you taking any medication?**If yes please list prescribed, over the counter or any recreational medications | Yes / No |
| **Do you have any long-term conditions?**If yes, please list | Yes / No |

I declare the information provided is accurate to the best of my knowledge and consent to the vaccinations advised.

Patient signature Date