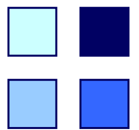

Liberton medical group

Please fill in this side only of the questionnaire—the nurse will go over it with you.

PLEASE NOTE—Payment is required prior to the travel advice session.

Title	First name	Surname

Address

Date of birth:

Destination:	Date of Travel:	Duration of stay:

Type of Trip : Package ☐ Short Business <3 months ☐ Long Business >3 months ☐ Touring / expedition ☐ Other ☐

Mode of travel : Plane ☐ Boat ☐ Car ☐ Train ☐ Bus ☐ Other ☐

Accommodation: Hotel ☐ Guest House ☐ Camping ☐ Relative/friend ☐ unknown ☐

Purpose of trip: Holiday ☐ Business ☐ Touring ☐ Visit relatives ☐

Have you ever had? :	Yes	No	Details
Previous serious illness eg Cancer, splenectomy :			
Allergies to eggs :			
Allergies to antibiotics :			
Allergies to Vaccines :			
HIV / AIDS :			
Steroid treatment in the last 3 months :			
Any other vaccination in the last 3 weeks :			
Are you pregnant / planning pregnancy or breast-feeding :			

	Required?	Expires	1st Dose	2nd Dose	3rd Dose
Polio					
Tetanus					
Tet / Dipth					
Diptheria					
Hep A					
Hep B					
Typhoid					
Meningococcal					

Malaria Prophylaxis Req'd? Yes ☐ No ☐

Chloroquine: ☐ Mefloquine: ☐ Doxycycline: ☐

Proguanil: ☐ Malarone: ☐ Other: ☐

Private Rx Given: ☐

Consent

I agree to receive the above Vaccinations on the advice received from the Nurse / Doctor

Signature: Date:

Payment Received: ☐

Total Paid for: ☐ Adults ☐ Children