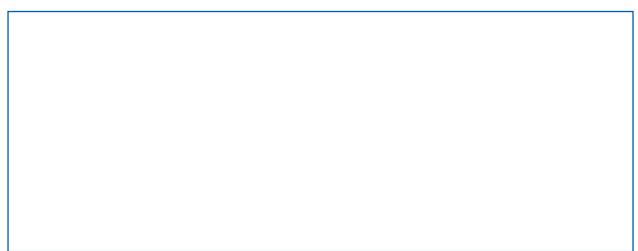
Travel Assessment Form

Fields marked with an asterisk (*) are compulsory.

Please use this form if you are travelling abroad and may require vaccinations. Make sure you hand this form in at least 6 weeks before you are due to travel, to allow for any arrangements to be made.

Patient Details				
Title (Mr. Mrs. etc.)	*Date of Birth			
*Surname				
*Forename(s)				
*Sex Assigned at Birth 🗌 Male 🗌 F	Female Other Please Specify			
*Gender 🗌 Male 🗌 F	Female Other Please Specify			
*Phone				
E-mail				
Trip Details				
*Departure Date				
*Trip Duration				

*Which country/countries are you visiting? Please include how long you intend to be in each country, and how far away from medical help you will be.

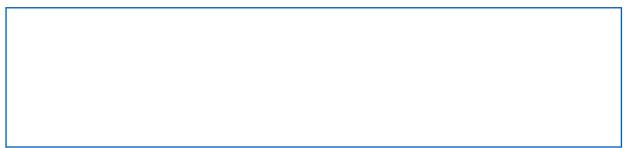


FME Felmores Medical Centre

Trip Description			
*What is the purpose of your trip?			
Holiday Business Other			
*What type of trip is it? Please tick all that apply.			
Package Holiday	Camping		
Self-Organised	Trekking		
Back-packing	Cruise Ship		
Other Please Specify			
*Where will you be staying?			
Hotel Friends or Family Other Please Specify			
*Who will you be travelling with?			
Alone	Nith Friends or Family 🛛 🗌 With a Group		
*What sort of area will you be staying in?			
Urban (city/town)	Rural (countryside)		
*What sort of activities will you be doing?			
Safari	Adventure 🗌 Beach/Pool		
Other Please Specify			

Your Medical History

*Please list any long-term or chronic medical conditions you have (e.g. Heart disease, asthma, diabetes etc).

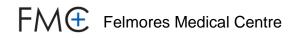


*Please list any current medications that you take (including oral contraception).

*Please list any allergies you have.

*Have you had a serious reaction to a vaccine in the past? If yes, please give details.

Yes No				
*Does having an injection make you feel faint?	Yes	No		
*Have you recently had an infection (e.g. cold or high temperature)?	🗌 Yes	🗆 No		
*Do you or any close family members have epilepsy?	🗌 Yes	🗌 No		
*Do you have any history of mental illness, including depression and anxiety?				
	🗌 Yes	🗆 No		
*Have you recently undergone Chemotherapy, Radiotherapy, or Steroid Treatment?				
	🗌 Yes	🗌 No		
*Are you pregnant, planning a pregnancy, or breast feeding?	🗌 Yes	🗌 No		
Please add any further information you feel may be relevant:				



*Date

Insurance				
*Have you taken out Travel Insurance for your trip?		🗆 Yes 🛛 No		
*Have you told your Insurance Company about any medical conditions you have?				
		🗆 Yes 🗌 No		
Vaccination History				
*Have you ever had any of the following vaccinations/tablets? Please tick as many as apply.				
Diptheria	Hepatitis A	Hepatitis B		
☐ Japanese B Enceph	🗆 Influenza	Malaria		
Meningitis	Polio	Rabies		
Tick Borne	Typhoid	☐ Yellow Fever		
*Have you had a Covid-19 Vaccination?				
□ No □ 1 st Dose □ 2 nd Dose Date of last dose				
Signature				
*Signature				