KING'S COLLEGE NHS HEALTH CENTRE
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PRIVATE PATIENT REGISTRATION FORM (TRAVEL CLINIC)

Today's Date: ___/___/_____

Family Name	
First Name (s)	
Date of Birth	
Address Including postcode	
Email address	
Preferred telephone contact number	
Your usual doctor's details *(Please be advised your GP needs to be in Central London CCG to access our service)*	

Please complete the Travel Questionnaire on the next page……………..

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Pre-Travel Questionnaire

Please provide as detailed answers as possible. All information is treated in strictest confidence.

Personal Details

Name: ______________________________ Date of Birth: ______________________________

Correspondence Address: ____

____

Telephone no: ______________________________ Email address: ______________________________

Travel Details

Date of departure: ______________________________ Date of return: ______________________________

Destination(s): *(please include* ***all*** *anticipated destinations)*

Accomodation: Camping=C, Hotel=H. Friends/Family=F, Backpacking/Hostels=B, Other=O

Country	Town/Region	Urban/Rural	Accommodation	Duration
e.g. Nepal	Lhasa	Rural	C	5 days

Purpose of Travel	Please Tick	Activities	Please Tick
Holiday	☐	Trekking/Camping	☐
Business	☐	Backpacking/Overlanding	☐
Religion	☐	Package holiday	☐
Medical elective	☐	Cruise ship	☐
Aid work	☐	Climbing/High altitude	☐
Visiting friends and/or family	☐	Safari	☐
Other *(please state):*		Healthcare work	☐
		Sports/Diving	☐
		Other	☐

Travel Planning *(please tick one)*:

Are you travelling: *Alone* ☐, *with family and/or friend(s)* ☐, *in a group* ☐?

Have you organised your trip: *by yourself* ☐, *through a travel agent* ☐, *through a voluntary organisation* ☐, *through work* ☐, *or other* ☐? *(please state):* ______________________________

It is recommended that you read the health advice for the country you are visiting before your appointment with the nurse. Please consult the following link: http://travelhealthpro.org.uk/countries

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Medical History

Do you have any medical conditions that may affect your trip? Yes ☐ No ☐

*If yes, please state:*____

Do you take any regular medication (including inhalers)? Yes ☐ No ☐

*If yes, please state:*____

Do you have any allergies to:

Medications Yes ☐ No ☐ *If yes, please state:*______________________________________

Food Yes ☐ No ☐ *If yes, please state:* ______________________________________

Eggs Yes ☐ No ☐ *If yes, please state:*______________________________________

Other Yes ☐ No ☐ *If yes, please state:* ______________________________________

Women only

Are you pregnant, planning pregnancy or breast feeding? Yes ☐ No ☐

Do you use an oral contraceptive pill? Yes ☐ No ☐

If yes, which one:____

Vaccination History

As far as you are aware, did you receive the normal childhood vaccination schedule in the United Kingdom? Yes ☐ No ☐

Have you ever had a reaction to any vaccines/immunisations? Yes ☐ No ☐

*If yes, please state:*____

Insurance *(please tick)*

Have you taken out travel health insurance? Yes ☐ No ☐

Are there any specific questions relating to you health during travel that you would like answered? *(please state)*

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Please indicate which of the following vaccinations you have previously received. ***Please bring any record of vaccinations to your appointment.***

Vaccine	Last received *(please tick)* **Full course**	**Booster**	**Date received**
DTP *(Diphtheria, Tetanus, Polio)*	☐	☐	DD/MM/YYYY
TD *(Tetanus, Diphtheria)*	☐	☐	DD/MM/YYYY
Tetanus alone	☐	☐	DD/MM/YYYY
Typhoid	☐	☐	DD/MM/YYYY
Hepatitis A	☐	☐	DD/MM/YYYY
Hepatitis B	☐	☐	DD/MM/YYYY
Meningococcal Group C	☐	☐	DD/MM/YYYY
Meningococcal Group A, C, Y, W135	☐	☐	DD/MM/YYYY
Pneumococcal	☐	☐	DD/MM/YYYY
Yellow Fever	☐	☐	DD/MM/YYYY
Influenza *('flu')*	☐	☐	DD/MM/YYYY
Rabies	☐	☐	DD/MM/YYYY
BCG *(for tuberculosis)*	☐	☐	DD/MM/YYYY
Others *(please state)*:			DD/MM/YYYY
………………………………..	☐	☐	DD/MM/YYYY
………………………………..	☐	☐	DD/MM/YYYY

Please read and sign below the following statement:
I certify that the above answers are true to my knowledge, and that the advice and vaccination recommendations I receive will be influenced by the answers I have provided.

Signature____ Date____

Name *(please print)*____

Thank you.