KING'S COLLEGE LONDON NHS HEALTH CENTRE
3RD FLOOR SOUTH EAST WING,
BUSH HOUSE
300 STRAND, LONDON WC2B 4PJ
TEL 020 4548 9842,
EMAIL: KINGSCOLLEGEHC@NHS.NET

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

GP PARTNER
DR MONA VAIDYA MBBS DFSRH MRCGP DRCOG
CENTRE MANAGER
MR DECLAN STOW
GP ASSOCIATES
• DR ERIC BRITTON MD MPH FRCGP • DR CHANG-SUN PARK BSC MBBS MRCGP DRCOG DFSRH • DR MELANIE MOUNTAIN MRCGP DRCOG DFFP DCH • DSRCH • DR SRISKANTHARAJAH ARUN-CASTRO MBBS MRCEM MRCGP MPH PGCE FHEA AKC • DR SIMON LEX BSC, MBCHB, MRCGP • DR MADELEINE FOSTER BMEDSC, MBCHB, MRCGP

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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.