SUTHERGREY HOUSE MEDICAL CENTRE
PRE-TRAVEL HEALTH &
VACCINATION ASSESSMENT
YELLOW FEVER

PLEASE COMPLETE IN BLOCK CAPITALS

SURNAME…………………………… FORENAME…………………………
TELEPHONE NO…………………… DATE OF BIRTH……………………
M/F……………………………………………………………………………
ADDRESS…………………………………………………………………….
……………………………………………………………………………….
DESTINATION
COUNTRY……………………………………………………………………

DO YOU HAVE ANY LONG-TERM MEDICAL CONDITIONS?.....Y/N……..
IF SO PLEASE GIVE DETAILS…………………………………………………
……………………………………………………………………………….
……………………………………………………………………………….
ARE YOU SUFFERING FROM ANY MINOR AILMENTS?.............Y/N……..
IF SO PLEASE GIVE DETAILS………………………………………………..
………………………………………………………………………………..

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS.

- **Have you had your Spleen removed? Yes/No**
- **Have you ever had a bad reaction to a Vaccine? Yes/No**
- **Do you have any allergies? Especially Eggs? Yes/No**
- **Are you taking any medication, including the contraceptive Pill, or have you been on antibiotics within the last 10 days? Yes/No**
- **Are you pregnant, breast-feeding or planning a Pregnancy? Yes/No**
- **Are you HIV positive? Yes/No**
- **Have you recently received treatment with radiotherapy, Chemiotherapy or Steroids? Yes/No**
- **Have you had any recent vaccinations? Yes/No**

IF YOU ANSWERED YES TO ANY OF THE ABOVE PLEASE GIVE DETAILS
……………………………………………………………………………….
……………………………………………………………………………….
……………………………………………………………………………….

For internal use only

Date of Vaccination Name/Status Vaccinator
Manufacturer
Batch No.
Expiry Date
Remarks/Special instructions

Consent for Vaccination……………………………………………Date…………..