East Neuk Pharmacy

Travel Vaccination Service – Travel Health Questionnaire

Please return to pharmacy so appointment can be arranged.

Patient Details

Full Name:

Date of Birth:

Telephone:

Email:

Medical Practice Name:

Travel Information

Destination Countries:

Departure Date:

Return Date:

Purpose of Travel: ☐ Holiday ☐ Work ☐ Visiting Family

Accommodation: ☐ Hotel ☐ Hostel ☐ Family Home ☐ Camping

Planned Activities:

Travel Style: ☐ Urban ☐ Rural ☐ Backpacking ☐ Trekking

Previous Vaccinations (Optional)

Pharmacy will check vaccination history with your medical practice.
If you would like to list any additional vaccines please record here.

Medical History

☐ Diabetes ☐ Heart disease ☐ Lung disease ☐ Immune condition

☐ Allergies ☐ Pregnant ☐ Breastfeeding ☐ Previous vaccine reaction

Regular medications:

Recent steroids / chemotherapy / immunosuppres

Declaration & Consent

I confirm the information provided is accurate to the best of my knowledge. I consent to East Neuk Pharmacy us ing this information to assess my travel health requirements and checking my vaccination history with my medic al practice where necessary.

Patient Signature (type name):

Date: