Yellow Fever Questionnaire

Puddletown Surgery Athelhampton Road Puddletown Dorset DT2
Tel: 01305 848333 Fax: 01305 848061

Name:	**Date of Birth:**	**Usual GP:**
Address:	**Home Telephone:** **Mobile:** **Work:**	**Surgery Address:**

Please enter your travel plans in the table below (including stopovers of any length):

Country	**Area/Town** (give as much detail as possible)	**From** (date)	**To** (date)

Medical Questionnaire

Please give details of all medical problems you have and any medication taken in the last 6 months (you may use the back of the form if required):	Date
Have you ever had a Yellow Fever vaccination in the past? Please give Date: If yes do you still have a certificate?	
Are you currently having, or have had in the last six months, any immunosuppressive treatment or drugs? (such as chemotherapy or radiotherapy for cancer, organ or bone marrow transplantation)	Yes / No
Do you have any thymus gland* or spleen disorder or immunodeficiency syndrome? (*not thyroid gland)	Yes / No
Are you HIV positive?	Yes / No
Are you Pregnant or breastfeeding an infant under the age of nine months old?	Yes / No
Are you allergic to eggs or chicken?	Yes / No
Are you allergic to Neomycin, Streptomycin or Polymixin?	Yes / No
Are you allergic to any other medication or had a reaction to any vaccines in the past? Please give details:	Yes / No
Have you received the MMR (Mumps, Measles and Rubella) vaccine in the last four weeks? If Yes, when?	Yes / No

Please turn over

I consent to the vaccination, have read the Yellow Fever Vaccination information leaflet and I am aware of the possible side-effects.	
Signature:	**Date:**

Doctor's Signature: (PSD for Nurse to administer STAMARIL injection)	**Date:**

For Office use:

Date received and scanned	
Injection reserved. (Nurse signature)	
Date of appointment	
Rescan and return to Travel Nurse	