

King Cross Surgery Travel Risk Assessment Form

Name: Address:	Date of Birth: Male : Female: Mobile number: Landline number: Email:		
PLEASE COMPLETE THIS FORM IN DETAIL. Including SPECIFIC locations to be visited.			
Countries to be visited	EXACT location or Region	City or Rural	Length of stay
1.			
2.			
3.			
Have you taken out Travel Insurance? Do you plan to travel abroad again in the future? If so where?			
DATE OF DEPARTURE:			
Trip type please tick ALL that apply -Holiday -Staying in hotel -Backpacking -Business -Cruise ship trip -Camping/Hostel -Expatriate - Safari -Adventure -Volunteer Work - Pilgrimage -Diving -Healthcare worker - Medical Tourism -Visiting friends/family.		Additional trip Info	
Please supply details of medical history			
	YES	NO	DETAILS
Are you fit and well			
Allergies including food, latex and medication			
Severe reaction to vaccine before			
Tendency to faint with injections			
Any operations in the past including, splenectomy Or Thymus gland removed			
Recent Chemo/Radiotherapy/Organ transplant/Steroid treatment			
Anaemia			
Bleeding or clotting disorders (inc history of DVT)			
Heart disease and or High BP			
Diabetes			
Disability			
Epilepsy/Seizures (including close family history)			
Gastrointestinal (stomach) complaints			
Liver and or kidney problems			
HIV/AIDS			
Immune system condition			
Mental health issues including anxiety and depression			

Neurological (nervous system) illness			
	YES	NO	DETAILS
Respiratory (Lung) disease			
Rheumatology (Joint) problems			
Spleen problems			
Any other conditions?			
Women only			
Are you pregnant?			
Are you breastfeeding?			
Are you planning pregnancy during or sooner after your trip?			
Are you currently taking any medications (including prescribed, purchased or a contraceptive method)			
Any additional information?			
Do you have a copy of the following information?			
Top tips travel advice	YES	NO	
Vaccine preventable diseases	YES	NO	
Nathnac – Yellow fever vaccination	YES	NO	
<i>The information I have given is, to the best of my knowledge correct.</i>			
Patient signature:			
Date:			

ADMIN ONLY

Date form received..... Form received by.....

Call back date given..... Date form scanned and passed to nurse.....