MINSTER MEDICAL PRACTICE
Cabourne Court, Cabourne Avenue, Lincoln, LN2 2JP
Tel: 01522 515797, Fax: 01522 515798
www.minstermedicalpractice.co.uk

TRAVEL RISK ASSESSMENT FORM

Please complete and return at least **8 weeks** before your travel date.

Name:	Date of Birth Male ☐ Female ☐
E-mail:	Telephone Number: Mobile Number:

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW

Date of Departure:	Total Length of Trip:

COUNTRY TO BE VISITED	EXACT LOCATION OR REGION	CITY OR RURAL	LENGTH OF STAY
1.			
2.			
3.			

Have you taken out travel insurance for this trip?
Do you plan to travel abroad again in the future?

TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY

Holiday	☐	Staying in Hotel	☐	Backpacking	☐	Additional Information	
Business trip	☐	Cruise ship trip	☐	Camping/Hostels	☐	Surgery	☐
Expatriate	☐	Safari	☐	Adventure	☐		
Volunteer work	☐	Pilgrimage	☐	Diving	☐		
Healthcare worker	☐	Medical tourism	☐	Visiting friends/family	☐		

PLEASE SUPPLY DETAILS OF YOUR PERSONAL MECIAL HISTORY

	YES	NO	DETAILS
Are you fit and well at this time			
Any allergies including food, latex, medication			
Severe reaction to a vaccine before			
Tendency to faint with injections			
Any surgical operations in the past, including e.g. thymus gland removed			
Recent chemotherapy/radiotherapy/organ transplant			
Anaemia			
Bleeding/Clotting disorders (Including history of DVT)			
Heart Disease (e.g. angina, high blood pressure)			
Diabetes			
Disability			
Epilepsy/seizures			
Gastrointestinal (stomach) complaints			
Liver and or kidney problems			
HIV/AIDS			
Immune System Condition			
Mental Health Issues (including anxiety, depression)			

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	YES	NO	DETAILS
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
Women Only			
Are you Pregnant?			
Are you breast feeding			
Are you planning pregnancy while away?			
Have you undergone FGM/been cut/circumcised			

Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?

PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST					
Tetanus/polio/diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies		Japanese Encephalitis		Tick Borne Encephalitis	
Yellow Fever		BCG		Other	
Malaria Tablets					

Please return your completed form to Reception

Thank you and we hope you have a pleasant trip

Minster Medical Practice