**TRAVEL RISK ASSESSMENT FORM** – To be completed by traveller prior to appointment

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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  □ Expatriate □ Safari □ Adventure  □ Volunteer work □ Pilgrimage □ Diving  □ Healthcare worker □ Medical tourism □ Visiting friends/family | | | | | | | | |
| **PLEASE SUPPLYDETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | | | | | | |
|  | | | **YES** | | | **NO** | **DETAILS** | |
| Are you fit and well today | | |  | | |  |  | |
| 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. your spleen or 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 | | |  | | |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| Mental health issues (including anxiety, depression) |  |  |  |
| Neurological (nervous system) illness |  |  |  |
| Respiratory (lung) disease |  |  |  |
| Rheumatology (joint) condition |  |  |  |
| Spleen problems |  |  |  |
| Any other conditions? |  |  |  |
| **Women only** |  |  |  |
| Are you pregnant? |  |  |  |
| Are you breast feeding? |  |  |  |
| Are you planning pregnancy while away? |  |  |  |

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| **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 | | | | | |

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| Any additional information |