

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

|  |   |                       |                               |
|--|---|-----------------------|-------------------------------|
| Name:  | Your country of origin:                                       |                       |                               |
|  | Date of birth:  |                       |                               |
|  | Male <input type="checkbox"/> Female <input type="checkbox"/> |                       |                               |
| E mail:  | Telephone number:   |                       |                               |
|  | Mobile number:  |                       |                               |
| <b>PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW</b>   |   |                       |                               |
| Date of departure:   |   | Total length of trip: |                               |
| <b>COUNTRY TO BE VISITED</b>   | <b>EXACT LOCATION OR REGION</b>                               | <b>CITY OR RURAL</b>  | <b>LENGTH OF STAY</b>         |
| 1.   |   |                       |                               |
| 2.   |   |                       |                               |
| 3.   |   |                       |                               |
| Have you taken out travel insurance for this trip?   |   |                       |                               |
| Do you plan to travel abroad again in the future?  |   |                       |                               |
| <b>TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY</b>   |   |                       |                               |
| <input type="checkbox"/> Holiday <input type="checkbox"/> Staying in hotel <input type="checkbox"/> Backpacking                      |   |                       | <u>Additional information</u> |
| <input type="checkbox"/> Business trip <input type="checkbox"/> Cruise ship trip <input type="checkbox"/> Camping/hostels            |   |                       |                               |
| <input type="checkbox"/> Expatriate <input type="checkbox"/> Safari <input type="checkbox"/> Adventure                               |   |                       |                               |
| <input type="checkbox"/> Volunteer work <input type="checkbox"/> Pilgrimage <input type="checkbox"/> Diving                          |   |                       |                               |
| <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Medical tourism <input type="checkbox"/> Visiting friends/family |   |                       |                               |
| <b>PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY</b>  |   |                       |                               |
|  | <b>YES</b>  | <b>NO</b>             | <b>DETAILS</b>                |
| 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) conditions                      |     |    |         |
| Spleen problems                                      |     |    |         |
| Any other conditions?                                |     |    |         |
| <b>Women only</b>                                    |     |    |         |
| Are you pregnant?                                    |     |    |         |
| Are you breast feeding?                              |     |    |         |
| Are you planning pregnancy while away?               |     |    |         |
| Have you undergone FGM / been cut / circumcised      |     |    |         |

| <b>Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?</b> |
|---|
|   |

| <b>PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST</b> |  |                       |  |                         |  |
|---|--|-----------------------|--|-------------------------|--|
| 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   |  |                       |  |                         |  |

| <b>Any additional information</b> |
|-----------------------------------|
|                                   |

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine*. RCN, London.
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.