**Travel Risk Assessment Form**

To register with our practice, ALL YOU NEED TO DO IS FILL IN THE FORM BELOW AND SUBMIT IT. Or you can print the forms and hand them in to reception or send them by post

Top of Form

* Name\*

First Last

* Address\*

Street AddressAddress Line 2CityState / Province / RegionZIP / Postal CodeCountry

* Date of Birth\*

Day

Month

Year

* NHS Number (if you know it)



* Contact Telephone numbers.(please include mobile phone if you have one)\*



Please add all relevant tel nos

* If you have an Email please add below



* Vaccination Status for Covid Vaccine\*
  +  I have had my 1st dose Pfizer vaccine only
  +  I have had my 1st dose Astra Zeneca vaccine only
  +  I have had my 1st dose Moderna vaccine only
  +  I have had my 1st and 2nd dose Pfizer vaccine
  +  I have had my 1st and 2nd dose Astra-Zeneca vaccine
  +  I have had my 1st and 2nd dose Moderna vaccine
  +  I am not vaccinated for Covid
* Date of Outbound Trip (Date of your Flight, coach or boat trip leaving the UK)\*

Day

Month

Year

* Date of Return Trip (Date of your Flight, coach or boat trip leaving the UK)\*

Day

Month

Year

* Ethnicity



Please include information about your ethnicity (optional)

* Please give a description of each country you are visiting on your trip and how many days you will be staying in each country\*



* Describe the type of trip\*
  +  Business
  +  Holiday self organised beach holiday
  +  Holiday self organised city holiday
  +  Holiday self organised campling or hostel stays
  +  Holiday self organised backpacking
  +  Holiday includes trip to jungle area or safari
  +  Holiday includes travel in rural areas
  +  Holiday includes travel at high altitude
  +  Holiday package beach holiday
  +  Holiday package city holiday
  +  Holiday package cruise ship
  +  Holiday package on a bus trip

Please tick all the boxes that apply to your trip

* Has you been diagnosed with any of the following medical conditions?\*
  +  No medical conditions
  +  Diabetes on insulin
  +  Diabeties on oral medication or diet only
  +  Asthma
  +  COPD (Chronic Lung condition)
  +  Stroke
  +  Heart Condition
  +  Dementia
  +  Mental Health Condition
  +  Epilepsy
  +  Parkinsons
  +  Rheumatoid Arthritis
  +  Osteoarthritis
  +  High Blood pressure
  +  Cancer (on active treatment)
  +  Thyroid problems
  +  Other

Please tick all those that apply to you

* Please list any allergies\*



* Have you ever had a serious reaction to a vaccine before particularly an anaphylactic type reaction?\*



Please describe what happened

* Please list any medications you are on. If possible include the dose you are on.\*



If you are not on any medication write none.

* Vaccination History\*
  +  Tetanus
  +  Typhoid
  +  Meningitis
  +  Rabies
  +  polio
  +  Hepatitis A
  +  Hepatitis B
  +  Yellow Fever
  +  Diptheria
  +  Japanese Encephalitis
  +  Tuberculosis
  +  Influenzae
  +  Cholera
  +  Malarial tablets
  +  Unsure

Have you ever had any of the following vaccines? Please tick all relevant boxes. Please write down the approximate date you last had this vaccine.

* Have you ever been diagnosed with a clot in your leg (deep vein thrombosis) or a clot in your lung (pulmonary embolism) ?



Please describe how you got the clot and if it was related to travel

* For women only is there any possibiilty you could be pregnant? Are you pregnant or currently breast-feeding?



* Has anyone in your family been diagnosed with any of the following medical conditions?
  +  No medical conditions in my family
  +  Diabetes on insulin
  +  Diabeties on oral medication or diet only
  +  Asthma
  +  COPD (Chronic Lung condition)
  +  Stroke
  +  Heart Condition
  +  Dementia
  +  Mental Health Condition
  +  Epilepsy
  +  Parkinsons
  +  Rheumatoid Arthritis
  +  Osteoarthritis
  +  High Blood pressure
  +  Cancer (on active treatment)
  +  Thyroid problems
  +  Other

For close family members (parents, siblings, grandparents, children) Please tick all those that apply to your family

Bottom of Form