**Travel Risk Assessment Form**

To be completed by the traveller a minimum of 4 weeks before traveling

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | Your country of origin: | | | |
| Email: | Date of Birth: | | | |
| 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  Business Trip  Cruise ship trip  Camping/Hostels  Expatriate  Safari  Adventure  Volunteer Work  Pilgrimage  Diving  Healthcare Worker  Medical tourism  Visiting friends / family  Additional information: | | | | |
| **PLEASE SUPPLY DETAILS 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 | |  |  |  |
| Mental Health issues (including anxiety, depression) | |  |  |  | |
| 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 Bone Encephalitis |  |
| Yellow Fever |  | BCG |  | Other |  |
| Malaria tablets | | | | | |

|  |
| --- |
| **Any other information:** |