HAWKESLEY MEDICAL PRACTICE

TRAVEL HEALTH ASSESSMENT FORM –this form must be completed and returned to us ***6 weeks before*** your departure date. You will be contacted if an appointment is necessary.

Name: Address:	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 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			
Anemia			
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?			
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					

Any additional information:

Please return your completed form to: Hawkesley Medical Practice, alternatively you can fax: 01214864201 or email: hawkesleymedical.practice@nhs.net

FOR THE NURSE TO COMPLETE ONLY

Vaccinations needed:	*Completed / date:*