**TRAVEL RISK ASSESSMENT FORM**

**T**o be completed by traveller prior to appointment

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | Date of birth: | | | | | | | | |
| Male □ Female □ | | | | | | | | |
| Mobile Number: | | | 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** | | |
| Any allergies including food, latex, medication | | | |  | | |  | |  | | |
| Severe reaction to a vaccine before | | | |  | | |  | |  | | |
| 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? | | | | | | |  | | | | |

**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