

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

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| Name: | Date of Birth |
| Male  Female  |
| Email: | Telephone number:Mobile number: |
| PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTION 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 |
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|  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 |  |

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| 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? |  |  |  |

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| **Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)? |
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| **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 |

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| **Any additional information** |