

**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 | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | |  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 | | | |  | |  |  | |
| 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** |