Travel Risk Assessment Form – to be completed by traveller prior to appointment

| | |
|---|---|
| Name:<br><br>Address: | Date of birth:<br>☐ Male ☐ Female<br>Telephone Number: |
| Email: | Mobile Number: |
| Registered GP Practice: | |

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. | | | |
| 4. | | | |
| 5. | | | |

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

Additional Information

| | | |
|---|---|---|
| ☐ Holiday | ☐ Staying in hotel | ☐ Backpacking |
| ☐ Business trip | ☐ Cruise /ship trip | ☐ Camping |
| ☐ Expatriate | ☐ Safari | ☐ Adventure |
| ☐ volunteer work | ☐ Pilgrimage | ☐ Diving |
| ☐ Healthcare worker | ☐ Medical tourism | ☐ Visiting friends /family |
| ☐ Working with animals | ☐ Agricultural | ☐ Horticultural |

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 operation sin 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 | | | |

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| | Yes | No | |
|---|---|---|---|
| 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 | | | |
| 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 |
| | | |

Any addition information

Thank you for taking the time to complete this form. We will contact you within 5 working days.