**Travel Risk Assessment Form**

To be completed prior to appointment

|  |
| --- |
| **Patient Details** |
| Name |   | Date of birth |  |
| Address |  | NHS number |  |
| Home Telephone |  |
| Email |  | Mobile Telephone |  |

|  |
| --- |
| **Travel Itinerary** |
|  | **Dates** | **Country** | **Exact location/region** | **City or Rural** | **Length of Stay** |
| **1.** |  |  |  |  |  |
| **2.** |  |  |  |  |  |
| **3.** |  |  |  |  |  |
| **4.** |  |  |  |  |  |

|  |
| --- |
| **Travel Information** (please tick all that apply) |
| **Type** | □ Holiday | □ Business trip | □ Volunteer work | □ Visiting friends/family |
|  | □ Expatriate | □ Cruise ship | □ Healthcare worker  | □ Pilgrimage |
| **Accommodation** | □ Hotel | □ Camping | □ Hostels | □ Friends/Family |
| **Activities** | □ Safari | □ Diving | □ Adventure |  |
| **Additional information:** |

|  |
| --- |
| **Medical History** |
|  | **Yes** | **No** | **Details** |
| Are you fit and well today  |  |  |  |
| 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?  |  |  |  |

|  |
| --- |
| **Information on any vaccines or malaria tablets taken in the past** |
| Tetanus/Polio/Diptheria |  | MMR |  | Influenza |  |
| Typhoid |  | Hepatitis A |  | Pneumococcal |  |
| Cholera |  | Hepatitis B |  | Meningitis |  |
| Japanese Encephalitis |  | Rabies |  | Yellow Fever |  |
| Tick Borne Encephalitis |  | BCG |  | Other |  |
| Malaria Tablets |  |

|  |
| --- |
| **Allergies** |
| (include food, latex and medication) |

|  |
| --- |
| **Medications** |
|  Please include all prescribed, purchased or contraceptive pill)**Acute Medication****Repeat Medication** |

|  |
| --- |
| **Further Information** |
| Have you taken out travel insurance for this trip?Do you plan to travel abroad again in the future? |
| **Other information:** |