Travel Risk Assessment Form

Please complete this form prior to your travel appointment and return to reception.

**Forename: Surname:**

**DOB: Age:**

**Address:**

**Postcode:**

**Telephone No: Mobile No:**

**Email address:**

**Date form completed: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Departure:**

**Return date or overall length of trip:**

|  |  |  |
| --- | --- | --- |
| **Countries to be visited (please also list the exact areas within the countries)** | **Length of stay** | **Away from medical help at destination, if so, how remote?** |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |

*If more than 5 countries to be visited - please continue list overleaf.*

**Please circle as appropriate below to best describe your trip.**

|  |  |  |  |
| --- | --- | --- | --- |
| **1. Type of trip:** | Business | Pleasure | Other |
| **2. Holiday Type:** | Package | Self-organised | Backpacking |
| Camping | Cruise Ship | Trekking |
| **3. Accommodation:** | Hotel/resort | Relatives | Other |
| **4. Travelling:** | Alone | With Family/friend | In a group |
| **5. Staying in area which is:** | Urban | Rural | Altitude |
| **6. Planned activities:** | Safari | Adventure | Other |

**Personal Medical History**

|  |
| --- |
| **Do you have any recent or past medical history of note?** (Including diabetes, heart or lung conditions, and thymus disorder): |
| **List any current or repeat medications:** |
| **Do you have any allergies for example to eggs, antibiotics, nuts?** |
| **Have you ever had a serious reaction to a vaccine given to you before?** |
| **Does having an injection make you feel faint?** |
| **Do you or any close family members have epilepsy?** |
| **Do you have any history or mental illness including depression or anxiety?** |
| **Have you recently undergone radiotherapy, chemotherapy or steroid treatment?** |
| **Women only: Are you pregnant or planning pregnancy or breastfeeding?** |
| **Have you taken out travel insurance and if you have a medical condition, informed the insurance company about his?** |
| **Please write below any further information which may be relevant:** |

**Vaccination History**

Have you ever had any of the following vaccinations/malaria tablets that we do not know about and if so when?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tetanus** |  | **Polio** |  | **Diphtheria** |  |
| **Typhoid** |  | **Hepatitis A** |  | **Hepatitis B** |  |
| **Meningitis** |  | **Yellow Fever** |  | **Influenza** |  |
| **Rabies** |  | **Jap B Enceph** |  | **Tick Borne** |  |
| **Other** |  | | | | |
| **Malaria Tabs** |  | | | | |