Travel Risk Assessment Form

To be completed prior to appointment



Page **1** of **3**

|  |  |  |  |
| --- | --- | --- | --- |
| **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 * Expatriate | * Business trip * Cruise ship | * Volunteer work * Healthcare worker | * Visiting friends/family * 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 a pregnancy while away? |  |  |  |

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

**Please amend this as necessary** (include food, latex and medication)

**Allergies**

# Medications

**Please amend this as necessary** (include prescribed, purchased or contraceptive pill)

# Acute Medication

# Repeat Medication

Have you taken out travel insurance for this trip?

Do you plan to travel abroad again in the future?

**Further Information**

**Other information:**