TRAVEL RISK ASSESSMENT FORM

Must be completed by traveller prior to appointment at the practice.

Name:	**Date of Birth**
Telephone Number: **Mobile Number:**	**Male** ☐ **Female** ☐

Please Supply Information About Your Trip in The Sections below

Date of Departure:	**Total Length of Trip:**

Which Country Are You Going To:	**Exact Location or Region**	**City or Rural?**	**Length of Stay There:**
1			
2			
3			

Have you taken out Travel Insurance for this trip?	**Yes** ☐	**No** ☐
Do you plan to travel abroad again in the future?	**Yes** ☐	**No** ☐

Please Tell Us About The Type of Activities You Will Be Doing and The Type of Accommodation You Will Be Staying In (e.g. doing extreme sports, and staying in a hotel)

This is important information so that we can guide you on the right vaccinations and give you the right information depending on what you will be doing during your visit and what risks you may face.

Please Tell Us Details of Your Personal Medical History			
	Yes	**No**	**Details**
Are you fit and well today			
Do you have any allergies including food, latex, medication			
Have you had a severe reaction to a vaccine before			
Do you have a tendency to faint with injections			
Have you had any surgical operations in the past, e.g. your spleen or thymus gland removed			
Have you recently had chemotherapy / radiography / organ transplant			
Do you have or have you ever had Anaemia			
Do you have or have you ever had any bleeding / clotting disorders (including history of DVT)			
Do you have Heart Disease (e.g. angina, high blood pressure)			
Do you have Diabetes			
Do you have a Disability			
Do you have Epilepsy / seizures			
Do you have any gastrointestinal (stomach) complaints			
Do you have any liver and / or kidney problems			
Do you have HIV/AIDS			
Do you have any immune system conditions			
Do you have any mental health issues (including anxiety, depression)			
Do you have a neurological (nervous system) illnesses			
Do you have any respiratory (lung) diseases			
Do you have any rheumatology (joint) conditions			
Do you have any spleen problems			

Do you have 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 medication or a contraceptive pill)? **Please give details**

Please supply information on any vaccines or malaria tablets you have taken in the past

Tetanus / polio / diptheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies *		Japanese Encephalitis *		Tick Borne Encephalitis *	
Yellow fever *		BCG		Other (please give details)	
Malaria Tablets					

* NB: Certain vaccinations are not provided as NHS prescriptions and will attract fees for the prescription, administration of the vaccine and for the purchase of the vaccine itself