TRAVEL RISK ASSESSMENT FORM – to be completed by traveller prior to appointment.

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| --- | --- |
| Name: | Date of Birth: |
| Male □ Female □ |
| Email: | Telephone number:Mobile number: |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTION 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. |  |  |  |
| 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** |
| □ Holiday | □ Staying in Hotel | □ Backpacking |
| □ Business Trip | □ Cruise ship trip | □ Camping/hostels |
| □ Expatriate | □ Safari | □ Adventure |
| □ Volunteer work | □ Pilgrimage | □ Diving |
| □Healthcare worker | □ Medical tourism | □ Visiting friends/family |
| **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 operations in the past, including your spleen or thymus gland removed? |  |  |  |
| Recent chemotherapy/radiotherapy/organ transplant? |  |  |  |
| Anaemia? |  |  |  |
| Bleeding/clotting disorders (including history of DVT)? |  |  |  |
| Heart disease (eg. 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? |  |  |  |
|  | **YES** | **NO** | **DETAILS** |
| 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? |  |  |  |
| Have you undergone FGM/been cut/circumcised? |  |  |  |

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| **Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)? |
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| **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 |  |
| Malaria Tablets |

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| **Is there any other additional information you think the travel nurse may need to be aware of:** |

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| **For office use only:** | Staff member who received form: | Date handed in: |