**DATE COMPLETED:……**

# TRAVEL RISK ASSESSMENT FORM

Ideally to be completed in full with as much information as possible by traveller 6-8 weeks prior to your appointment as some vaccines are courses which need to be completed prior to travelling.

## Please return form to reception and phone for your travel vaccine requirements after three working days.

| | |
|---|---|
| Name: | Date of birth: |
| E-mail: | Telephone: |
| Male ☐ Female ☐ | Mobile: |

**PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW**

| Countries to be visited | Location/Region | City/Rural | Length of stay |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |

| | |
|---|---|
| Date of departure: | Length of trip: |
| Have you taken out travel insurance for this trip? | Do you plan to travel again in the future? |

**TYPE OF TRAVEL AND PURPOSE OF TRIP (please tick all that apply)**

| | | | | | | |
|---|---|---|---|---|---|---|
| Holiday | ☐ | Staying in hotel | ☐ | Backpacking | ☐ | Additional Information |
| Business trip | ☐ | Cruise ship trip | ☐ | Camping/hostels | ☐ | |
| Expatriate | ☐ | Safari | ☐ | Adventure | ☐ | |
| Volunteer work | ☐ | Pilgrimage | ☐ | Diving | ☐ | |
| Healthcare worker | ☐ | Medical tourism | ☐ | Visiting friends/family | ☐ | |

**PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALERIA 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- | | | | | |

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

| | YES | NO | DETAILS |
|---|---|---|---|
| Are you fit and well today | | | |
| Any allergies including food, latex and medication | | | |
| Have you ever had a severe reaction to a vaccine before | | | |
| Do you 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 (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 (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 a planning pregnancy while away? | | | |

| **Any additional information** |
|---|
| |