TRAVEL RISK ASSESSMENT FORM – To help ensure that you are adequately immunised against all diseases you are at risk of being exposed to when travelling abroad, it is important that you provide us with the following information prior to the appointment time.

FIRST NAME:	**SURNAME:**
DATE OF BIRTH:	TELEPHONE NUMBER:
EMAIL :	MOBILE TEL NO:
MALE: YES NO	FEMALE: YES NO

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP BELOW

Date of Departure:		Total Days away:	
WHAT COUNTRY ARE YOU VISITING	**EXACT LOCATION ON 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 ☐ CAMPING/HOSTELS ☐ EXPATRIATE ☐ SAFARI

☐ ADVENTURE ☐ VOLUNTEER WORK ☐ PILGRIMAGE ☐ DIVING

☐ HEALTHCARE WORKER ☐ MEDICAL TOURISM ☐ VISITING FRIENDS/FAMILY

ADDITIONAL INFORMATION:

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			
Tendancy to faint with injections			
Any surgical operations in the past, including e.g. your spleen or thymus gland removal			

Medical History Cont/d	**YES**	**NO**	**DETAILS**
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?			
Questions for Women Only:			
Are you pregnant			
Are you breast feeding			
Are you planning pregnancy			

Are you currently taking any medication (Including prescribed, purchased or a contraceptive pill)?

If Yes please list these below: (or if indicated on Registration form please indicate)

Refer to Registration form YES

PLEASE PROVIDE INFORMATION OF ANY VACCINATIONS YOU HAVE RECEIVED IN THE PAST

Vaccination	Month/Year	Vaccination	Month/Year	Vaccination	Month/Year
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					

Any Additional Information: