Travel risk assessment form

Date: ……../……/……

Both pages ideally to be completed by the traveller prior to appointment.

Title, Name AND Address (details of the person receiving the vaccine)**:**	**Date of Birth: ……../……/…….** **Male** □ **Female** □
Mobile or Landline: **Email:**	**GP Surgery's Name & Address:** GP Fax No (if known): Would you like your GP to be notified of this consultation? **Yes** □ **No** □

Please supply information about your trip in the sections 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.			
4			

Have you taken out travel insurance for this trip? Yes □ No □

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 details of your personal medical history

	YES	**NO**	**DETAILS**
Are you fit and well today			
Any allergies including food (esp. **egg**), latex, medication			
Severe reaction to a vaccine before			
Tendency to faint with injections			
Have you had any vaccinations in the past 4 weeks			
Any surgery in the past, esp. if to do with spleen or thymus			
Recent (last 12 months) chemotherapy/radiotherapy/organ transplant / immunosuppressive drugs/ steroids			

	YES	NO	DETAILS
Bleeding /clotting disorders (including history of DVT)			
Heart disease			
Anaemia			
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 pregnancy while away?			

Are you currently taking <u>any medication</u> (including prescribed, purchased or a contraceptive pill)?

If yes, please list names and doses:

Please tick the vaccines you had before and provide the date(s) of these vaccinations					
Tetanus/polio/diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies		Japanese Encephalitis		Tick Borne Encephalitis	
Yellow fever		BCG		Other	
Have you had any antimalarial medication(s) before? If yes, which one(s)?					

HOW DID YOU HEAR ABOUT OUR TRAVEL CLINIC?

Our store's signs/poster/leaflet □ GP practice □ Our website □ Social media □ Friends/family □ Other:.....