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TRAVEL RISK ASSESSMENT FORM

**This form can be completed prior to your travel appointment to help the Nurse with your travel risk assessment.**

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| **Personal details:** |
| Name |  | Date of birth |
| Contact Tel No: |  |  | Male |  | Female |  |  |
| **Dates of trip:** |
| Date of departure |
| Return date or overall length of trip |
| **Itinerary and purpose of visit:** |
| Country **and** location to be visited | Length of stay | Away from medical help atdestination, if so, how remote? |
| 1. |  |  |
| 2 |  |  |
| 3 |  |  |
| **Please tick as appropriate below to best describe your trip:** |
| 1. Type of trip | Business |  | Pleasure |  | Other - Please specify |  |
| 2. Holiday type | Package |  | Self organised |  | Backpacking |  |
| 3. Mode of transport | Plane |  | Bus |  | Other- Please specify |  |
| 4. Accommodation | Hotel |  | Relatives/family home |  | Other- Please specify |  |
| 5. Travelling | Alone |  | With family/friend |  | In a group |  |
| 6. Staying in area which is | Urban |  | Rural |  | Altitude |  |
| 7. Planned activities | Safari |  | Adventure |  | Other- Please specify |  |

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| **Personal medical history:** |
| Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions) |
| List any current or repeat medications |
| Do you have any allergies for example to eggs, antibiotics, nuts or latex? |
| Have you ever had a serious reaction to a vaccine given to you before? |
| Does having an injection make your feel faint? |
| Do you or any close family members have epilepsy? |
| Do you have any history of mental illness including depression or anxiety? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |
| *Women only:* Are you pregnant or planning pregnancy or breast-feeding? |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this? |
| Please write below any further information which may be relevant: |

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| **Vaccination history:** |
| Have you ever had any of the following vaccinations/malaria tablets and if so when? |
| Tetanus |  | Polio |  | Diphtheria |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | Tick BorneEncephalitis |  |
| Other- Please specify |  |
| Malaria tablets |  |

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| ***Travel history:*** |
| Please specify what travelling experience you have: |