**TRAVEL RISK ASSESSMENT FORM**

**PLEASE HAND IN 8 WEEKS BEFORE TRAVEL**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | **Your country of origin:** | | | | | |
| **Date of birth:** | | | | | |
| **Male □ Female □** | | | | | |
| **E mail:** | | **Telephone number:**  **Mobile number:** | | | | | |
| **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.** |  | | | |  | |  |
| **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 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, latex, medication** | | |  |  | |  | |
| **Severe reaction to a vaccine before** | | |  |  | |  | |
| **Tendency to faint with injections** | | |  |  | |  | |
| **Any surgical operations in the past, including e.g., 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** | | |  |  | |  | |

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| **Mental health issues (including anxiety, depression)** |  |  |  |
| **Neurological (nervous system) illness** |  |  |  |
| **Respiratory (lung) disease** |  |  |  |
| **Rheumatology (joint) conditions** |  |  |  |
| **Spleen problems** |  |  |  |
| **Any other conditions?** |  |  |  |
| **Below women only** |  |  |  |
| **Are you pregnant?** |  |  |  |
| **Are you breast feeding?** |  |  |  |
| **Are you planning pregnancy while away?** |  |  |  |
| **Have you undergone FGM / been cut / circumcised** |  |  |  |

**Any additional information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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** | | | | | |

**OFFICE USE ONLY –**

**Dated Received: Staff Initials:**