**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:**

|  |
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| **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:**