

**TRAVEL RISK ASSESSMENT FORM - PATIENT**

**(ONLY** complete this form if you are travelling greater than six weeks from date of assessment – **please note** – some travel immunisations are **not** available on the NHS and will incur a charge)

Name:	Date of Birth:
Address	Male <input type="checkbox"/> Female <input type="checkbox"/>
	Telephone No:
Email:	Mobile No:

**Please supply information about your trip in the sections below**

Date of departure:		Total length of trip:	
<b>Country to be visited</b>	<b>Exact Location or region</b>	<b>City or Rural</b>	<b>Length of stay</b>
1.			
2.			
3.			

**Type of travel and purpose of trip – please tick all that apply**

<input type="checkbox"/>	Holiday	<input type="checkbox"/>	Staying in hotel	<input type="checkbox"/>	Backpacking	Additional Information:
<input type="checkbox"/>	Business trip	<input type="checkbox"/>	Cruise ship trip	<input type="checkbox"/>	Camping/hostels	
<input type="checkbox"/>	Expatriate	<input type="checkbox"/>	Safari	<input type="checkbox"/>	Adventure	
<input type="checkbox"/>	Volunteer work	<input type="checkbox"/>	Pilgrimage	<input type="checkbox"/>	Diving	
<input type="checkbox"/>	Healthcare worker	<input type="checkbox"/>	Medical tourism	<input type="checkbox"/>	Visiting friends/family	

**Please supply details of your personal medical history**

	Yes	No	Details
Are you fit and well			
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 kidney problems			
HIV/AIDS			
Immune system condition			

	Yes	No	Details
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
<b>Women only</b>			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			

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

**Please supply information on any vaccines or malaria tablets taken in the past – DATE GIVEN:**

Tetanus/Diphtheria/Polio	MMR	Influenza
Typhoid	Hepatitis A	Pneumococcal
Cholera	Hepatitis B	Meningitis ACWY
Rabies	Japanese Encephalitis	Tick Borne Encephalitis
Yellow Fever	BCG	Other
Malaria tablets	Pertussis	

**Any additional information**

**Patient Signature:** ..... **Date:** .....