**Travel Risk Assessment Form**

To be completed by the traveller a minimum of 4 weeks before traveling

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| Name: | Your country of origin: |
| Email: | Date of Birth: |
| 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[ ]  Business Trip [ ]  Cruise ship trip [ ]  Camping/Hostels[ ]  Expatriate [ ]  Safari [ ]  Adventure[ ]  Volunteer Work [ ]  Pilgrimage [ ]  Diving[ ]  Healthcare Worker [ ]  Medical tourism [ ]  Visiting friends / familyAdditional information: |
| **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 |  |  |  |
| 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? |  |  |  |
| Have you undergone FGM / been cut / circumcised  |  |  |  |

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| **Are you currently taking any medication? (including prescribed, purchased or a contraceptive pill)** |
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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 Bone Encephalitis |  |
| Yellow Fever |  | BCG |  | Other |  |
| Malaria tablets |

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| **Any other information:** |