**Travel Risk Assessment Form** – Ideally to be completed by traveller prior to appointment

| | |
|---|---|
| Name | Country of Origin |
| Email | Date of Birth |
| Male ☐ Female ☐ Non Binary ☐ | Telephone number<br>Mobile Number |
| Please Supply information about your trip: | |

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|---|
| Departure Date : |
| Total Length of Trip : |

| Country to be Visited | Exact Location or Region | City or Rural | Length of Stay |
|---|---|---|---|
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What modes of transport will you be using ? ……

Have you taken out Travel insurance for this trip? ……

Do you plan to travel abroad 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 / family |

Additional Information :

Please supply details of your personal medical history

| | Yes | No | Details |
|---|---|---|---|
| Are you fit and well today? | | | |
| Any Allergies including food, latex, medication | | | |
| Have you, or anyone in your family, had a sever reaction to a vaccine or malaria medication before? | | | |
| Tendency to faint with injections? | | | |
| Any Surgical operations in the past, including open heart surgery, spleen or thymus gland removal? | | | |
| Recent Chemotherapy / Radiotherapy / organ transplant | | | |

| | | | |
|---|---|---|---|
| Anaemia | | | |
| Bleeding / clotting disorders, including history of DVT? | | | |
| Heart Disease, eg Angina, high blood pressure | | | |
| Diabetes | | | |
| Addiitional needs and / or disability | | | |
| Epilepsy / Seizures or in a first degree relative? | | | |
| Gastrointestinal (stomach) Complaints | | | |
| Liver and or Kidney problems | | | |
| HIV / Aids | | | |
| Immune system condition eg Blood Cancer | | | |
| Mental Health Issues (including anxiety, depression | | | |
| Neurological nervous system illness | | | |
| Respiratory (lung) Disease | | | |
| Rheumatology (joint) Conditions | | | |
| Spleen problems | | | |
| Any other conditions ? | | | |
| Are you or your partner pregnant or planning a pregnancy? | | | |
| Are you breast feeding (if applicable) | | | |
| Have you or anyone in your family undergone FGM / Been cut or circumcised? | | | |

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

| 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 | |
| Covid – 19 Dates, Brands etc: | | | | | |
| Malaria Tablets: | | | | | |

Clinical Details

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Clinician Name……

Date of Consultation……..