**TRAVEL RISK ASSESSMENT FORM**

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| 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 | |  |  |  | | |
| 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 borne encephalitis |
| Yellow fever | BCG | Other |
| Malaria Tablets |  |  |

**Any additional information**