

**Travel Risk Assessment Form – to be completed by traveller**

|  |  |
| --- | --- |
| **Name:** | **Date of Birth:** |
| **Email:** | **Telephone No:** |
| **Supply Information about your trip in the sections below** |
| **Date of Departure:** | **Total Length of stay:** |
| **Country’s to be visited**  | **Location/ Region**  | **City/ Rural**  | **Length of Stay** |
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| **Have you taken out travel insurance for this trip?** YES / NO |  **Do you plan to travel abroad again in the future?** YES/ NO |
| **Type of travel and purpose of trip – please tick all that apply** |
|  Holiday Business trip Expatriate Volunteer Work Healthcare Worker Staying in hotel |
|  Cruise Ship trip Safari Pilgrimage Medical Tourism Backpacking Camping/hostels |
| Adventure Diving Altitude Visting friends/ family  |
| **Please supply details of your personal medical history** |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** |  |
| 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 |  |  |  |
| Epilepsy/ seizures |  |  |  |
| Gastrointestinal (stomach) complaints |  |  |  |
| HIV/ AIDS |  |  |  |
| Immune system conditions |  |  |  |
| Mental health issues (including anxiety, depression) |  |  |  |
| Neurological (nervous system) illness |  |  |  |
| Respiratory (lung) disease |  |  |  |
| Rheumatology (joint) conditions |  |  |  |
| Any other conditions |  |  |  |
| Are you pregnant? |  |  |  |
| Are you breast feeding? |  |  |  |
| Are you planning pregnancy while away? |  |  |  |
| **Are You Currently taking Any Medications** (including prescribed, purchased or a contraceptive pill)? |
|  |
| **Please supply information on any vaccines or malaria tablets taken in the past** |
| **Vaccine** | **Date** | **Vaccine** | **Date** |
| Tetanus/polio/diphtheria |  | Japanese Encephalitis |  |
| Typhoid |  | Tick Bourne Encephalitis |  |
| Hepatitis A |  | Meningitis |  |
| Hepatitis B |  | Pneumococcal |  |
| Yellow Fever |  | Influenza |  |
| Rabies |  | MMR |  |
| Cholera |  | BCG |  |
| **Malaria tablets** |
| **Signature:**  | **Date:** |

BHC 13 Travel Health

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Date: Jan 2014

Review : Jan2016

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