

**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** | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
|  | | | **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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