

Routine Vaccinations & Travel Vaccinations

TRAVEL RISK ASSESSMENT FORM- ideally to be completed by traveller prior to appointment

| | |
|--------|---|
| Name: | Date of Birth |
| | Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Email: | 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

- | | | |
|--|---|--|
| <input type="checkbox"/> Holiday | <input type="checkbox"/> Staying in Hotel | <input type="checkbox"/> Backpacking |
| <input type="checkbox"/> Business Trip | <input type="checkbox"/> Cruise ship trip | <input type="checkbox"/> Camping/Hostels |
| <input type="checkbox"/> Expatriate | <input type="checkbox"/> Safari | <input type="checkbox"/> Adventure |
| <input type="checkbox"/> Volunteer Work | <input type="checkbox"/> Pilgrimage | <input type="checkbox"/> Diving |
| <input type="checkbox"/> Healthcare Worker | <input type="checkbox"/> Medical tourism | <input type="checkbox"/> Visiting Friends/Family |

Additional Information:

PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY

| | YES | NO | DETAILS |
|--|-----|----|---------|
| Are you fit and well today? | | | |
| Any allergies inc food, latex, medication? | | | |
| Severe reaction to a vaccine before? | | | |
| Tendency to faint with injections? | | | |
| Any surgical operations in past? | | | |
| Recent chemotherapy/radiotherapy/transplant? | | | |
| Anaemia? | | | |
| Bleeding/clotting disorders? | | | |
| Heart Disease (e.g angina, high blood pressure)? | | | |
| Diabetes? | | | |
| Disability? | | | |
| Epilepsy/Seizures? | | | |
| Gastrointestinal (stomach) complaints? | | | |
| Liver and or kidney problems? | | | |
| | | | |

| | YES | NO | DETAILS |
|--|-----|----|---------|
| HIV/Aids? | | | |
| Immune system condition? | | | |
| Mental health issues? | | | |
| Neurological (nervous system) illness? | | | |
| Respiratory (lung) disease? | | | |
| Rheumatology (joint) conditions? | | | |
| Spleen problems? | | | |
| Any other conditions? | | | |
| Woman only | | | |
| Are you pregnant? | | | |
| Are you breast feeding? | | | |
| Are you planning pregnancy while away? | | | |
| Have you undergone FGM/been cut/circumcised? | | | |

Are you currently taking any medication?

PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST

| | | | | | |
|--------------------------|--|-----------------------|--|-------------------------|--|
| Tetanus/polio diphtheria | | MMR | | Influenza | |
| Typhoid | | Hep A | | Pneumococcal | |
| Cholera | | Hep B | | Meningitis | |
| Rabies | | Japanese encephalitis | | Tick Borne Encephalitis | |
| Yellow Fever | | BCG | | Other | |
| Malaria Tablets | | | | | |

Any additional information?