

**TRAVEL RISK ASSESSMENT FORM** – ideally to be completed by traveller prior to appointment.

Name:	Your country of origin:		
	Date of birth:		
	Male <input type="checkbox"/> Female <input type="checkbox"/>		
E mail:	Telephone number:		
	Mobile number:		
<b>PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW</b>			
Date of departure:		Total length of trip:	
<b>COUNTRY TO BE VISITED</b>	<b>EXACT LOCATION OR REGION</b>	<b>CITY OR RURAL</b>	<b>LENGTH OF STAY</b>
1.			
2.			
3.			
Have you taken out travel insurance for this trip? Do you plan to travel abroad again in the future?			
<b>TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY</b>			
<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			<u>Additional information</u>
<b>PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY</b>			
	<b>YES</b>	<b>NO</b>	<b>DETAILS</b>
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			

	YES	NO	DETAILS
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
<b>Women only</b>			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			
Have you undergone FGM / been cut / circumcised			

<b>Are you currently taking any medication</b> (including prescribed, purchased or a contraceptive pill)?

<b>PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST</b>					
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, brand etc.)					
Malaria Tablets					

<b>Any additional information</b>

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine*. RCN, London.
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.