

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"/> | |
| 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 | | | |
| <input type="checkbox"/> Holiday <input type="checkbox"/> Staying in hotel <input type="checkbox"/> Backpacking <u>Additional information</u> <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 | | | |
| 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 | | | |

Form devised and created by Jane Chiodini © Updated 2017

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| | YES | NO | DETAILS |
|--|-----|----|---------|
| 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 | | | |

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

| 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

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

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

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