

Travel Risk Assessment Form

Name:

Date of birth:

Address:

Telephone:

Email:

Travel details

Departure date:

Total length of trip:

Return date:

Country/Destinations

Region

Length of stay

1.

2.

3.

4.

5.

6.

Purpose of trip

Adventure/Gap year

Aid work/Emergency response:

Business/Work trip:

Charity/Volunteer:

Cruise:

Diving:

Health worker

Holiday:

Long term/Expatriate:

Medical treatment:

Pilgrimage:

Visiting friends and family:

Other:

Medical History

Please tick either the 'Yes' or 'No' answer box. If you answer yes to any of the questions, please give dates and full details overleaf.

		Yes	No
1)	Do you have, or have you had any serious illness, disability or mobility problem?	<input type="checkbox"/>	<input type="checkbox"/>
2)	Are you receiving regular treatment or follow up with your GP/ Hospital specialist?	<input type="checkbox"/>	<input type="checkbox"/>
3)	Have you had <u>any</u> hospital admissions?	<input type="checkbox"/>	<input type="checkbox"/>
4)	Have you ever had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5)	Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
6)	Have you had any travel related illness/injury which required assessment/treatment in hospital?	<input type="checkbox"/>	<input type="checkbox"/>
7)	Do you have/have you had a condition which could impair your immune system (including taking any medicines/treatment in the last 12 months that could impair your immune system)?	<input type="checkbox"/>	<input type="checkbox"/>
8)	Do you think you have a condition which may be affected by travel?	<input type="checkbox"/>	<input type="checkbox"/>
9)	Do you have any specific health concerns regarding your proposed trip?	<input type="checkbox"/>	<input type="checkbox"/>
10)	Have you ever experienced any mental health issues, even mild anxiety or depression?	<input type="checkbox"/>	<input type="checkbox"/>

Further Details

Please provide any other important information regarding your health, including problems experienced with previous travel:

Please continue on a separate sheet if necessary.

Are you taking any form of medication?

Yes No

If yes please give details, including prescribed/self-treatment/over-the-counter remedies and contraception

Name of Medication	Dose and Frequency	Condition

Women only

Are you pregnant, breastfeeding or planning pregnancy whilst travelling?

Yes No

Babies and children only

Current weight:

Date:

Do you have travel health insurance? Yes No

Next section is for health professional use only:

Risk Management Checklist	Discussed (✓)	Comments
1. Medical prep		
2. Journey		
3. Safety		
4. Environmental		
5. Food and water		
6. Vector-borne risks		
7. Sexual health		
8. Blood-borne virus		
9. Skin/sun		
10. Psychological health		

Signature..... Date.....

Vaccine Record				
Vaccines	Date	Brand, Batch & Expiry Date	Dose, method & site	Given by
BCG and Mantoux Test Mantoux result:				
Cholera Primary course: Boosters				
Diphtheria/Tetanus/Polio				
Hepatitis A: Primary course: Boosters				
Hepatitis A/B: Primary course: Boosters				
Hepatitis A/Typhoid Primary course: Boosters				
Hepatitis B: Primary course: Boosters				
Japanese Encephalitis: Primary course: Boosters				

Influenza				
Japanese Encephalitis Primary course: Boosters				
Meningitis ACWY				
MMR				
Tick-borne encephalitis Primary course: Boosters				
Typhoid				
Yellow fever				
Any other vaccines				

Malaria

Antimalarials	Date prescribed	Dose & amount dispensed	Batch number & expiry date	Given by
Atovaquone & proguanil				
Chloroquine				
Doxycycline				
Mefloquine				
Proguanil				
Emergency standby				

Importance of bite avoidance and urgent medical attention for symptoms discussed?

YES NO

Any other advice or comments: