**NETTLEHAM MEDICAL PRACTICE**

**TRAVEL RISK ASSESSMENT FORM**

|  |  |
| --- | --- |
| Appointment Date and time |  |
| Appointment with |  |

(Appointment to be booked when patient presents completed questionnaire

One form per person travelling)

|  |  |
| --- | --- |
| Name | Date of birth |
| Male □ Female □ |
| **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?  |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY** |
| □ Holiday □ Staying in hotel □ Backpacking Additional information□ Business trip □ Cruise ship trip □ Camping/hostels□ Expatriate □ Safari □ Adventure□ Volunteer work □ Pilgrimage □ Diving□ Healthcare worker □ Medical tourism □ Visiting friends/family |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** |
|  | **YES** | **NO** | **DETAILS** |
| Any allergies including food, latex, medication |  |  |  |
| Severe reaction to a vaccine before |  |  |  |
| Tendency to faint with injections |  |  |  |
| Recent chemotherapy/radiotherapy/organ transplant |  |  |  |
| Bleeding /clotting disorders (including history of DVT) |  |  |  |
| HIV/AIDS |  |  |  |
| Immune System Condition |  |  |  |
|  |  |  |  |
| **Women Only** |  |  |  |
| Are you pregnant? |  |  |  |
| Are you breastfeeding |  |  |  |
| Are you planning pregnancy? |  |  |  |
| Have you undergone FGM/been cut/circumcised |  |  |  |
|  |  |  |  |
| Any other conditions? |  |  |  |

**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 ACWY |  |
| Rabies |  | JapaneseEncephalitis |  | Tick BorneEncephalitis |  |
| Yellow fever |  | BCG |  | Other |
| Malaria Tablets |

**Any additional information**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note:

* Please return completed travel vaccination form and make an appointment with the nurse AT LEAST 4 WEEKS before the date of travel
* If you decide to have the recommended vaccinations the full payment will be required prior to ordering

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