**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 |  | Japanese  Encephalitis |  | Tick Borne  Encephalitis |  |
| 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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