

# The Elms Medical Practice

## TRAVEL RISK ASSESSMENT FORM

Please complete this form prior to your travel appointment and return to reception

Personal details						
<b>Name:</b>	<b>Date of birth:</b>					
	<b>Male [ ] Female [ ]</b>					
<b>Easiest contact telephone number</b>						
<b>E mail</b>						
Dates of trip						
<b>Date of Departure</b>						
<b>Return date or overall length of trip</b>						
Itinerary and purpose of visit						
<b>Country to be visited</b>	<b>Length of stay</b>	<b>Away from medical help at destination, if so, how remote?</b>				
1.						
2.						
3.						
<b>Please tick as appropriate below to best describe your trip</b>						
<b>1. Type of trip</b>	Business		Pleasure		Other	
<b>2. Holiday type</b>	Package		Self organised		Backpacking	
	Camping		Cruise ship		Trekking	
<b>3. Accommodation</b>	Hotel		Relatives / family home		Other	
<b>4. Travelling</b>	Alone		With family / friend		In a group	
<b>5. Staying in area which is</b>	Urban		Rural		Altitude	
<b>6. Planned activities</b>	Safari		Adventure		Other	

<b>Personal medical history</b>
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions, disorder)
List any current or repeat medications
Do you have any allergies for example to eggs, antibiotics, nuts?
Have you ever had a serious reaction to a vaccine given to you before?
Does having an injection make you feel faint?
Do you or any close family members have epilepsy?
Do you have any history of mental illness including depression or anxiety?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
<i>Women only:</i> Are you pregnant or planning pregnancy or breast feeding?
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?
Please write below any further information which may be relevant

<b>Vaccination History</b>					
Have you ever had any of the following vaccinations / malaria tablets and if so when?					
Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
Other					
Malaria tablets					

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

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