Danderhall Medical Practice
Travel Risk Assessment Form

Please complete all of the questions on this form and hand back to reception. The practice nurse will then contact you to arrange an appointment.

Personal Details

Name: Date of Birth: / /

Gender: MALE / FEMALE (please circle) Telephone number:

Do you smoke? NEVER

YES Cigarettes/e-Cigarettes/Cigars/Pipe (please circle)

STOPPED SMOKING Date when you stopped: / /

Dates of Trip

Date of Departure: / / Return date: / /

Itinerary and Purpose of Visit

Country to be visited	Length of stay	Away from medical help at destination? If so how remote?
1.		
2.		
3.		

Type of trip (please tick)	☐ Business	☐ Pleasure	☐ Other
Holiday Type	☐ Package ☐ Camping	☐ Self organised ☐ Cruise ship	☐ Backpacking ☐ Trekking
Accomodation	☐ Hotel	☐ Relatives/ family home	☐ Other
Travelling	☐ Alone	☐ With family/friend	☐ In a group
Staying in which area	☐ Urban	☐ Rural	☐ Altitude
Planned activities	☐ Safari	☐ Adventure	☐ Other

Personal Medical History

Do you have any recent or past medical history of note? This includes Diabetes, heart or lung conditions, thymus disorder?

_____

_____

List any current or repeat medications: _____

_____

		If YES please provide further details
Do you have any allergies for example to eggs, antibiotics, nuts?	YES/NO	
Have you ever had a serious reaction to a vaccine given to you before?	YES/NO	
Does having an injection make you feel faint?	YES/NO	
Do you or any close family members have epilepsy?	YES/NO	
Do you have any history of mental illness including depression or anxiety?	YES/NO	
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?	YES/NO	
Women only – Are you pregnant or planning a pregnancy or breast feeding?	YES/NO	
Have you taken out travel insurance? If you have a medical condition have you informed the insurance company about it?	YES/NO	

Please give any further information that may be relevant, including any future travel plans.

_____

_____

Vaccination History

Have you ever had any of the following vaccinations/malaria tablets (please tick)

☐ Tetanus	☐ Polio	☐ Diphtheria	☐ Typhoid
☐ Hepatitis A	☐ Hepatitis B	☐ Meningitis	☐ Yellow Fever
☐ Influenza	☐ Rabies	☐ Jap B Enceph	☐ Tick Borne
Other? (please provide further details)		Malaria tablets? (please provide further details)	

For discussion when risk assessment is carried out at your appointment

☐ I have no reason to think I am 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

Patient signature: Date: / /

Signed on behalf of the practice: Date: / /