

**TRAVEL RISK ASSESSMENT FORM** – ideally to be completed by traveller prior to appointment.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 |                                                               |                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------|-------------------------------|
| Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                 | Your country of origin:                                       |                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 | Date of birth:                                                |                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 | Male <input type="checkbox"/> Female <input type="checkbox"/> |                               |
| E mail:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                 | Telephone number:                                             |                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 | Mobile number:                                                |                               |
| <b>PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 |                                                               |                               |
| Date of departure:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 | Total length of trip:                                         |                               |
| <b>COUNTRY TO BE VISITED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>EXACT LOCATION OR REGION</b> | <b>CITY OR RURAL</b>                                          | <b>LENGTH OF STAY</b>         |
| 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |                                                               |                               |
| 2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |                                                               |                               |
| 3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |                                                               |                               |
| <p>Have you taken out travel insurance for this trip?</p> <p>Do you plan to travel abroad again in the future?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |                                                               |                               |
| <b>TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 |                                                               |                               |
| <input type="checkbox"/> Holiday <input type="checkbox"/> Staying in hotel <input type="checkbox"/> Backpacking<br><input type="checkbox"/> Business trip <input type="checkbox"/> Cruise ship trip <input type="checkbox"/> Camping/hostels<br><input type="checkbox"/> Expatriate <input type="checkbox"/> Safari <input type="checkbox"/> Adventure<br><input type="checkbox"/> Volunteer work <input type="checkbox"/> Pilgrimage <input type="checkbox"/> Diving<br><input type="checkbox"/> Healthcare worker <input type="checkbox"/> Medical tourism <input type="checkbox"/> Visiting friends/family |                                 |                                                               | <u>Additional information</u> |
| <b>PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                 |                                                               |                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>YES</b>                      | <b>NO</b>                                                     | <b>DETAILS</b>                |
| Are you fit and well today                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                 |                                                               |                               |
| Any allergies including food, latex, medication                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 |                                                               |                               |
| Severe reaction to a vaccine before                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                 |                                                               |                               |
| Tendency to faint with injections                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                 |                                                               |                               |
| Any surgical operations in the past, including e.g. your spleen or thymus gland removed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                 |                                                               |                               |
| Recent chemotherapy/radiotherapy/organ transplant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                 |                                                               |                               |
| Anaemia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                 |                                                               |                               |
| Bleeding /clotting disorders (including history of DVT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                 |                                                               |                               |
| Heart disease (e.g. angina, high blood pressure)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |                                                               |                               |
| Diabetes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                 |                                                               |                               |
| Disability                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                 |                                                               |                               |
| Epilepsy/seizures                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                 |                                                               |                               |
| Gastrointestinal (stomach) complaints                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                 |                                                               |                               |
| Liver and or kidney problems                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                 |                                                               |                               |
| HIV/AIDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                 |                                                               |                               |
| Immune system condition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                 |                                                               |                               |

|                                                      | YES | NO | DETAILS |
|------------------------------------------------------|-----|----|---------|
| Mental health issues (including anxiety, depression) |     |    |         |
| Neurological (nervous system) illness                |     |    |         |
| Respiratory (lung) disease                           |     |    |         |
| Rheumatology (joint) conditions                      |     |    |         |
| Spleen problems                                      |     |    |         |
| Any other conditions?                                |     |    |         |
| <b>Women only</b>                                    |     |    |         |
| Are you pregnant?                                    |     |    |         |
| Are you breast feeding?                              |     |    |         |
| Are you planning pregnancy while away?               |     |    |         |
| Have you undergone FGM / been cut / circumcised      |     |    |         |

|                                                                                                           |
|-----------------------------------------------------------------------------------------------------------|
| <b>Are you currently taking any medication</b> (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              |  |
| Rabies                                                                         |  | Japanese encephalitis |  | Tick borne encephalitis |  |
| Yellow fever                                                                   |  | BCG                   |  | Other                   |  |
| Malaria Tablets                                                                |  |                       |  |                         |  |

|                                   |
|-----------------------------------|
| <b>Any additional information</b> |
|                                   |

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine*. RCN, London.
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.