GRANTA Medical Practices

TRAVEL RISK ASSESSMENT FORM

To be completed by traveller prior to appointment

Name:	Date of Birth:
Address:	Male □ Female □
	Preferred Contact Number:
Email address:	Can we leave a message? Yes □ No □

About your trip

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?			
Do you plan to travel abroad again in the future?			

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		

Personal medical history details

	Yes	No	Details
What is your smoking status? Never smoked □ Smoker □ Ex-smoker □			
Are you fit and well today?			
Do you have any allergies, inc. food, latex, medication?			
Have you previously experience a severe reaction to a vaccine?			
Do you have a tendency to faint with injections?			
Have you had any surgical operations in the past?			
Have you had your thymus gland removed?			
Have you recently had chemotherapy or radiotherapy?			
Have you had an organ transplant?			
Do you suffer from anaemia?			
Do you have any bleeding or clotting disorders, for example, a history of DVT?			
Do you have heart disease, eg. angina, high blood pressure?			

Do you have (please tick as appropriate):	Yes	No	
Diabetes			
Disability			
Epilepsy / seizures			
Gastrointestinal (stomach) complaints			
Liver and/or kidney problems			
HIV/AIDs			
Immune system condition			
Mental health issues (inc. anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			

Women only	Yes	No	
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy whilst away?			
Are you currently taking any medication (including prescribed, purchased or contraceptive pill)?			

Have you had any of the following vaccines / tablets 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			
Malaria Tablets		COVID-19			

Any additional information:	
Patient signature:	**Date:**

FOR OFFICE USE ONLY

Length of time needed for first appointment:	
Date and time of first appointment:	
Nurse:	
Receptionist:	