

Travel Risk Assessment Form

Name:

Date of birth:

Address:

Telephone:

Email:

Travel details

Departure date:

Total length of trip:

Return date:

Country/Destinations

Region

Length of stay

1.

2.

3.

4.

5.

6.

Purpose of trip

Adventure/Gap year:

Aid work/Emergency response:

Business/Work trip:

Charity/Volunteer:

Cruise:

Diving:

Health worker:

Holiday:

Long term/ Expatriate:

Medical treatment:

Pilgrimage:

Visiting friends and family:

Other:

Medical History

Please tick either the 'Yes' or 'No' answer box. If you answer yes to any of the questions, please give dates and full details overleaf.

| | Yes | No |
|--|--------------------------|--------------------------|
| 1) Do you have, or have you had any serious illness, disability or mobility problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you receiving regular treatment or follow up with your GP/hospital specialist? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you had <u>any</u> hospital admissions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Have you ever had any surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Do you have any allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Have you had any travel related illness/injury which required assessment/treatment in hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Do you have/have you had a condition which could impair your immune system (including taking any medicines/treatment in the last 12 months that could impair your immune system)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Do you think you have a condition which may be affected by travel? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Do you have any specific health concerns regarding your proposed trip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Have you ever experienced any mental health issues, even mild anxiety or depression? | <input type="checkbox"/> | <input type="checkbox"/> |

Further Details

Please provide any other important information regarding your health, including problems experienced with previous travel:

Please continue on a separate sheet if necessary.

Are you taking any form of medication?

Yes No

If yes please give details, including prescribed/self-treatment/over-the-counter remedies and contraception

| Name of Medication | Dose and Frequency | Condition |
|--------------------|--------------------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Women only

Are you pregnant, breastfeeding or planning pregnancy whilst travelling?

Yes No

Babies and children only

Current weight:

Date:

Do you have travel health insurance? Yes No

Next section is for health professional use only:

| Risk Management Checklist | Discussed (✓) | Comments |
|----------------------------------|--------------------------|-----------------|
| 1. Medical prep | | |
| 2. Journey | | |
| 3. Safety | | |
| 4. Environmental | | |
| 5. Food and water | | |
| 6. Vector-borne risks | | |
| 7. Sexual health | | |
| 8. Blood-borne virus | | |
| 9. Skin/sun | | |
| 10. Psychological health | | |

Signature..... Date.....

| Vaccine Record | | | | |
|---|-------------|---------------------------------------|--------------------------------|-----------------|
| Vaccines | Date | Brand, Batch & Expiry Date | Dose, method & site | Given by |
| BCG and Mantoux Test Mantoux result: | | | | |
| Cholera Primary course: Boosters | | | | |
| Diphtheria/Tetanus/Polio | | | | |
| Hepatitis A: Primary course: Boosters | | | | |
| Hepatitis A/B: Primary course: Boosters | | | | |
| Hepatitis A/Typhoid Primary course: Boosters | | | | |
| Hepatitis B: Primary course: Boosters | | | | |
| Influenza | | | | |
| Japanese Encephalitis Primary course: Boosters | | | | |
| Meningococcal ACWY | | | | |

| | | | | |
|--|------------------------|------------------------------------|---------------------------------------|-----------------|
| MMR | | | | |
| Tick-borne encephalitis | | | | |
| Primary course: | | | | |
| Boosters | | | | |
| Typhoid | | | | |
| Yellow fever | | | | |
| Any other vaccines | | | | |
| Malaria | | | | |
| Antimalarials | Date prescribed | Dose & amount dispensed | Batch number & expiry date | Given by |
| Atovaquone & proguanil | | | | |
| Chloroquine & Proguanil | | | | |
| Doxycycline | | | | |
| Mefloquine | | | | |
| Emergency standby | | | | |
| Importance of bite avoidance and urgent medical attention for symptoms discussed? | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| Any other advice or comments: | | | | |
| | | | | |

Yellow fever risk assessment: it is required that health professionals undertaking risk assessment for yellow fever vaccination use a [yellow fever specific checklist](#) in addition to that used in the general travel health risk assessment.