**BRAEHEAD MEDICAL PRACTICE**

**TRAVEL RISK ASSESSMENT FORM**

**To be completed by traveller ideally prior to appointment**

| | |
|---|---|
| Name: | Date of Birth: |
| Address: | Male Female |
| E mail: | Telephone Number:<br>Mobile Number: |

**PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW**

| 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 | | |

**PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY**

| | YES | NO | DETAILS |
|---|---|---|---|
| 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 spleen | | | |
| 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 kidney problems | | | |
| HIV/AIDS | | | |
| Immune system condition | | | |
| Mental health issues (including anxiety, depression | | | |

| | YES | NO | DETAILS |
|---|---|---|---|
| Neurological (nervous system) illness | | | |
| Respiratory (lung) disease | | | |
| Rheumatology (joint) conditions | | | |
| Spleen problems | | | |
| Any other conditions? | | | |
| **Woman only** | | | |
| Are you pregnant? | | | |
| Are you breast feeding? | | | |
| Are you planning pregnancy while away? | | | |

**Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?**

**PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MARLARIA 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

**ANY ADDITIONAL INFORMATION**