

Arden Medical Centre

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TRAVEL RISK ASSESSMENT FORM

Please complete this form prior to your travel appointment and return to reception/nurse

Personal details:							
Name		Date of birth					
		Male		<input type="checkbox"/>	Female		<input type="checkbox"/>
Dates of trip:							
Date of departure							
Return date or overall length of trip							
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.							
Please tick as appropriate below to best describe your trip:							
1. Type of trip	Business	<input type="checkbox"/>	Pleasure	<input type="checkbox"/>	Other	<input type="checkbox"/>	
2. Holiday type	Package	<input type="checkbox"/>	Self organised	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>	
3. Accommodation	Hotel	<input type="checkbox"/>	Relatives/family home	<input type="checkbox"/>	Other	<input type="checkbox"/>	
4. Travelling	Alone	<input type="checkbox"/>	With family/friend	<input type="checkbox"/>	In a group	<input type="checkbox"/>	
5. Staying in area which is	Urban	<input type="checkbox"/>	Rural	<input type="checkbox"/>	Altitude	<input type="checkbox"/>	
6. Planned activities	Safari	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Other	<input type="checkbox"/>	

Personal medical history:
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)
List any current or repeat medications
Do you have any allergies for example to eggs, antibiotics, nuts?
Have you ever had a serious reaction to a vaccine given to you before?
Does having an injection make your feel faint?
Do you or any close family members have epilepsy?
Do you have any history of mental illness including depression or anxiety?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
<i>Women only:</i> Are you pregnant or planning pregnancy or breast-feeding?
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?
Please write below any further information which may be relevant:

Vaccination history:					
Have you ever had any of the following vaccinations/malaria tablets and if so when?					
Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne Encephalitis	
Other					
Malaria tablets					

I agree to the vaccinations recommended by the practice and have read the patient information leaflet. I accept the risks associated with these vaccinations.

I am aware that some vaccinations are charged for and agree to payment at the time of the appointment.

Signed _____

Date _____