Apples Medical Centre

TRAVEL RISK ASSESSMENT FORM

Please Contact Reception on 01935 812633 to book a Travel Clinic appointment
Please complete this form prior to your travel appointment and return to the practice **at least 48 hours prior to your appointment**

Personal details	
Name:	**Date of birth:** **Male ☐ Female ☐**
Contact telephone number	
E mail	
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**	**Over 24 hours travelling distance from medical help?**
1.		
2.		
3.		
4.		
5.		

Please tick as appropriate below to best describe your trip

1. Type of trip	Business	☐	Pleasure	☐	Other	☐
2. Holiday type	Package	☐	Self organised	☐	Backpacking	☐
	Camping	☐	Cruise ship	☐	Trekking	☐
3. Accommodation	Hotel	☐	Relatives / family home	☐	Other	☐
4. Travelling	Alone	☐	With family / friend	☐	In a group	☐
5. Staying in area which is	Urban	☐	Rural	☐	Altitude	☐
6. Planned activities	Safari	☐	Adventure	☐	Other	☐

Personal medical history		
Do you have any medical history of note? (Including diabetes, heart or lung conditions, thymus disorder)		
List any current or repeat medications		
Do you have any allergies for example to eggs, antibiotics, nuts ?	Yes ☐	No ☐
Have you ever had a serious reaction to a vaccine given to you before?	Yes ☐	No ☐
Does having an injection make you feel faint?	Yes ☐	No ☐
Do you or any close family members have epilepsy?	Yes ☐	No ☐
Do you have any history or mental illness including depression or anxiety?	Yes ☐	No ☐
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?	Yes ☐	No ☐
Women only: Are you pregnant or planning pregnancy or breast feeding?	Yes ☐	No ☐
Have you taken out travel insurance and informed the insurance company if you have a medical condition?	Yes ☐	No ☐
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	☐	JapB Encephalitis	☐	Tick Borne Encephalitis	☐		
Other	☐						
Malaria Tablets	☐						

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed _____ Date _____