TRAVEL RISK ASSESSMENT

LURGAN MEDICAL PRACTICE

Name: ……

☐ Male ☐ Female **Date of Birth:** ……..……..

Easiest contact telephone number: ……

Date of departure: …… **Length of trip:** ……

Countries to be visited	Length of stay	Away from medical help at destination? If "yes" how remote?
First stop:		
Second stop:		
Third stop:		

Which of the following best describe your trip?

Type of trip ☐ Business ☐ Pleasure ☐ Other	**Accommodation** ☐ Hotel ☐ Relatives/family home ☐ Other	**Travelling** ☐ Alone ☐ With family or friends ☐ In a group	
Holiday type ☐ Package ☐ Camping ☐ Self-organised	☐ Group-organised ☐ Cruise Ship ☐ Backpacking ☐ Trekking	**Staying in an area which is** ☐ Rural ☐ Urban ☐ Altitude	**Planned activities** ☐ Safari ☐ Adventure ☐ Other

Do you have any recent or past medical history of note?

☐ No ☐ Yes ……

Please list any current or repeat medications: ……

……

……

Do you have any allergies for example eggs, antibiotics, nuts etc? ☐ No ☐ Yes

Have you ever had a serious reaction to a vaccine given to you before? ☐ No ☐ Yes

Does having an injection make you feel faint? ☐ No ☐ Yes

Do you or any close family member have epilepsy? ☐ No ☐ Yes

Do you have any history of mental illness including depression or anxiety? ☐ No ☐ Yes

Have your recently undergone radiotherapy, chemotherapy or steroid treatment? ☐ No ☐ Yes

(Women only) Are you pregnant or planning pregnancy or breast feeding? ☐ No ☐ Yes

Have you taken out travel insurance? If you have a medical condition, have your informed the insurance company about it? ☐ No ☐ Yes

Please give any further information that may be relevant, including any future travel plans.

……

……

Have you ever had any malaria tablets or the following vaccinations and if so when?

☐ Tetanus ..... ☐ Polio …… ☐ Diphtheria ……

☐ Typhoid ..... ☐ Hepatitis A …… ☐ Hepatitis B ……...

☐ Meningitis ..... ☐ Yellow Fever …….. ☐ Influenza ……..

☐ Rabies ..... ☐ Jap B Enceph …… ☐ Tick Borne ……

☐ Other ……..

☐ Malaria tablets ……

Please send my Prescription to ……

For discussion when the 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:** ……...