**Claremont Bank Surgery – Travel Risk Assessment Form**

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| **DEPARTURE DATE:** | **TOTAL LENGTH OF TRIP:** |

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| **NAME:** | **DOB:** |
| **ADDRESS:** |
| **MOBILE: HOME TEL:** |

*\*\*REMEMBER TO ENSURE TO BOOK TRAVEL INSURANCE\*\**

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| **COUNTRY VISITING** | **LOCATION/REGION** | **CITY/RURAL** | **LENGTH OF STAY** |
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| **TYPE OF TRAVEL AND PURPOSE OF TRIP (please tick all that apply):** |
| BackpackingCamping/hostelsAdventureDivingVisiting friends/familyStaying in hotelCruise ship tripSafariPilgrimageMedical tourismHolidayBusiness tripExpatriateVolunteer workHealthcare worker |
| **ADDITIONAL INFORMATION:** |

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| **PLEASE SUPPLY DETAILS OF YOUR MEDICAL HISTORY** (please tick Y/N)**:** |
|  | **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. your spleen or thymus gland removed  |  |  |  |
|  | **YES** | **NO** | **Details** |
| Recent chemotherapy/radiotherapy/ organ transplant |  |  |  |
| Anaemia |  |  |  |
| Bleeding/ clotting disorders (including DVT history) |  |  |  |
| Heart disease (e.g. angina, high blood pressure) |  |  |  |
| Diabetes |  |  |  |
| Disability |  |  |  |
| Epilepsy / seizures |  |  |  |
| Gastrointestinal (stomach) complaints |  |  |  |
| Liver or kidney problems |  |  |  |
| HIV/ AIDS |  |  |  |
| Immune system condition |  |  |  |
| Mental health issues (anxiety, depression) |  |  |  |
| Neurological (nervous system) illness |  |  |  |
| Respiratory (lung) disease |  |  |  |
| Rheumatology (joint) conditions |  |  |  |
| Spleen problems |  |  |  |
| Any other conditions |  |  |  |
| Are you pregnant |  |  |  |
| Are you breast feeding |  |  |  |
| Are you planning pregnancy while away |  |  |  |

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| **ARE YOU CURRENTLY TAKING ANY MEDICATION** (including prescribed, purchased or a contraceptive pill): |
| \* \* \* \* \* \*\* \* \*  |

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| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST:** |
| Tetanus/polio/diptheria |  | MMR |  | Influenza |  |
| Typhoid |  | Hepatitis A |  | Pneumococcal |  |
| Cholera |  | Hepatitis B |  | Meningitis |  |
| Rabies |  | Japanese Encephalitis |  | Tick Bourne Encephalitis |  |
| Yellow fever |  | BCG |  | Malaria tablets |  |
| Other: |

**ADDITIONAL:**