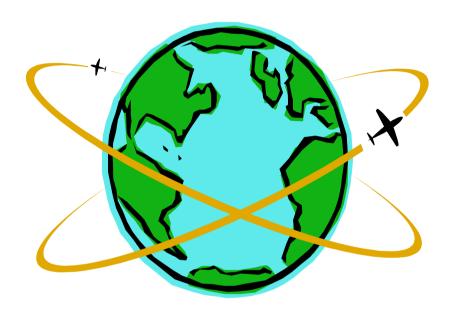
BROOKVALE PRACTICE

TRAVEL RISK ASSESSMENT FORM



PLEASE ENSURE THAT THIS FORM IS COMPLETED IN AS MUCH DETAIL AS POSSIBLE AND RETURNED TO THE PRACTICE PRIOR TO YOUR APPOINTMENT

SHOULD PAYMENT BE REQUIRED, WE ACCEPT CASH, CHEQUE WITH CHEQUE CARD AND PAYMENT BY DEBIT / CREDIT CARD.

| PERSONAL DETAILS |
|---|
| Name: |
| D.O.B: |
| Address: |
| |
| Telephone: |
| Email: |
| |
| PERSONAL MEDICAL HISTORY |
| Do you have any recent or past medical history of note? (Including diabetes, heart or lung conditions, and thymus gland disorders?) |
| |
| Do you have any allergies? E.g. eggs, antibiotics, nuts? |
| Have you ever had a reaction to a vaccine given to you before? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |
| Do you have any history of mental illness including anxiety or depression? |
| Women only: Are you pregnant, planning pregnancy or breast feeding? |
| Have you taken out travel insurance and if you have a medical condition, informed the company about this? |
| Please give any further information which may be relevant, including any future travel plans. |
| |
| |
| |
| |

TRAVEL ITINERARY

| Date of depo | arture: | Return date or overall length of trip: | | | | | |
|---|-------------------------------|--|--|--|--|--|--|
| Country / Countries to be visited (Please detail length of stay in each country): | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| PLEASE CIRC | LE AS APPROPRIATE AND PROV | VIDE FURTHER INFORMATION WHERE SPECIFIED | | | | | |
| <u>Trip type:</u> | | | | | | | |
| Business | Pleasure | Other (Please specify below) | | | | | |
| | | | | | | | |
| Holiday type | <u>:</u> | | | | | | |
| Please circle | all that apply to your trip – | | | | | | |
| Package | Self organised | Backpacking Camping | | | | | |
| Cruise Ship | Trekking | Safari Adventure | | | | | |
| Accomodati | ion: | | | | | | |
| Hotel | Relatives or family home | Other (Please specify below) | | | | | |
| | | | | | | | |
| <u>паченінд.</u> | | | | | | | |
| Alone | With family / Friend | In a group | | | | | |
| Staying in ar | area which is: | | | | | | |
| Urban | Rural Altitude | Other (Please specify below) | | | | | |
| | | | | | | | |
| | | | | | | | |

VACCINATION & MEDCATION HISTORY

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

| TETANUS | |
|-------------------------|--|
| POLIO | |
| DIPTHERIA | |
| TYPHOID | |
| HEPATITIS A | |
| HEPATITIS B | |
| MENINGITIS | |
| YELLOW FEVER | |
| INFLUENZA | |
| RABIES | |
| JAPANESE ENCEPHALITIS | |
| TICK BORNE ENCEPHALITIS | |
| MMR | |
| OTHER / MALARIA TABLETS | |
| | |
| | |
| | |
| | |

CURRENT MEDICATION

Please list all medications currently being taken, including over the counter products:

FOR OFFICIAL USE

| Patients name: | | | | | | | |
|---------------------------------------|-----------------------|------|-------------------------------------|--|--|--|--|
| Travel risk assessment performed Yes | | | No | | | | |
| | | | NO | | | | |
| Travel vaccinations re | ecommended for this t | rip: | | | | | |
| Teatnus | Yes | No | Malaria prevention advice / | | | | |
| Diptheria | Yes | No | chemoprophylaxis recommendations | | | | |
| Polio | Yes | No | Chloroquine / proguanil | | | | |
| Hepatitis A | Yes | No | Atavaquone / proguanil | | | | |
| Hepatitis B | Yes | No | Chloroquine | | | | |
| Typhoid | Yes | No | Mefloquine | | | | |
| Yellow fever Yes | | No | Doxycycline | | | | |
| Men ACWY Yes No | | No | Treatment & prevention advice given | | | | |
| Rabies | Yes | No | Yes No | | | | |
| Jap Encephalitis | Yes | No | Vaccinations given: | | | | |
| Cholera | Yes | No | Ü | | | | |
| Other | | | | | | | |
| <u>Travel advice / leaflets given</u> | | | | | | | |
| Food/ water | Traveller's diarrhoea | | Hep B & HIV Insect bite prevention | | | | |
| Animal bites | Accidents | | Insurance Air travel | | | | |
| Sun and heat Protection | Websites | | Travel record card supplied | | | | |
| Signed: | | | Position: Date: | | | | |