

## Deddington Health Centre - Travel Risk Assessment Form

Name:	Date of Birth:		
	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
email:	Telephone No.		
	Mobile No.		

Please supply information about your trip in the sections below.

Date of departure:		Total duration:		
Country to be visited	Exact location or region	City	Rural	Duration
1				
2				
3				

Have you taken out travel insurance for this trip?

Type of travel and purpose of trip - *Please tick all that apply*

<input type="checkbox"/> Holiday	<input type="checkbox"/> Staying in hotel	<input type="checkbox"/> Backpacking
<input type="checkbox"/> Business trip	<input type="checkbox"/> Cruise ship trip	<input type="checkbox"/> Camping/hostels
<input type="checkbox"/> Expatriate	<input type="checkbox"/> Safari	<input type="checkbox"/> Adventure
<input type="checkbox"/> Volunteer work	<input type="checkbox"/> Pilgrimage	<input type="checkbox"/> Diving
<input type="checkbox"/> Healthcare worker	<input type="checkbox"/> Medical tourism	<input type="checkbox"/> Visiting friends/family

Additional Info:

Please supply details of your personal medical history

	Yes	No	Details:
Any allergies including food, latex, medication?			
Severe reaction to a vaccine before?			
Tendency to faint with injections?			
Any surgical operations in the past, including for example			
Recent chemotherapy/radiotherapy/organ transplant?			
Anaemia?			
Bleeding/clotting disorders (including history of DVT)?			
<b>Women only</b>			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			

Are you currently taking any medication (including prescribed, purchased or a contraceptive pill)?

Please supply information on any vaccines or malaria tablets taken in the past

Tetanus/olio/diphtheria		MMR		Influenza	
Typhoid		Hepatitis A		Pneumococcal	
Cholera		Hepatitis B		Meningitis	
Rabies		Japanese Encephalitis		Tick Borne Encephalitis	
Yellow Fever		BCG		Other	

Malaria Tablets

Any additional information

