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Travel Risk Assessment Form

Please complete this form and return it to the surgery prior to your travel appointment.

PERSONAL DETAILS

Name:		Today's date:	
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth:	Easiest contact Tel. No.
Email:			

ITINERARY and DATES

Departure date: (From UK)	Return date: (To UK)
Country to be visited (Including stopovers)	Length of stay In an emergency, how long will it take to get medical help?
1.	
2.	
3.	

PURPOSE OF VISIT (Circle the words that best describe your trip)

1. Type of trip	<i>Business</i>	<i>Pleasure</i>	<i>Other</i>
2. Travel to destination	<i>Aeroplane</i> <i>Train</i>	<i>Boat</i> <i>Bus</i>	<i>Car</i> <i>Other</i>
3. Holiday type	<i>Package</i> <i>Camping</i> <i>Other</i>	<i>Self-organised</i> <i>Cruise ship</i>	<i>Backpacking</i> <i>Trekking</i>
4. Accommodation	<i>Hotel</i> <i>Other</i>	<i>Relatives</i>	<i>family home</i>
5. Travelling	<i>Alone</i>	<i>With family/friend</i>	<i>In a group</i>
6. Staying in area which is:	<i>Urban</i> <i>Coast</i>	<i>Rural</i>	<i>At Altitude</i>
7. Planned activities	<i>Safari</i>	<i>Adventure</i>	<i>Other</i>

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PERSONAL MEDICAL HISTORY

Please list any recent or past medical history of note:

(This includes diabetes, heart or lung conditions, thyroid disorder, splenectomy, high blood pressure.)

List any current or repeat medications:

Please list any allergies?

(e.g. eggs, antibiotics, nuts)

Have you ever had a serious reaction to a vaccine in the past?

YES

NO

Does having an injection make you feel faint?

YES

NO

Do you or any close family member have epilepsy?

YES

NO

Do you have any history of mental illness including depression or anxiety?

YES

NO

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

YES

NO

Women only:

YES

NO

Are you pregnant or planning pregnancy or breast feeding?

Women only:

YES

NO

Are you on the hormonal contraceptive pill?

Have you taken out travel insurance?

YES

NO

If you have a medical condition, have you informed the insurance company about this?

YES

NO

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

VACCINATION HISTORY

Please give the dates when you had any of the following vaccinations:

<u>Vaccination</u>	<u>Date</u>	<u>Vaccination</u>	<u>Date</u>
Tetanus		Hepatitis A	
Diphtheria		Hepatitis B	
Polio		Typhoid	
Meningitis		Rabies	
Yellow Fever		Jap B Enceph	
Tick Borne Enceph		Influenza	
Other:			

Which malaria tablets have you used in the past:

Are there any questions you would like to discuss?

