

ST. THOMAS MEDICAL GROUP

Travel Risk Assessment Form

Please complete this form prior to your travel appointment and bring to your first appointment

Personal Details					
Name:				Date of Birth:	
Address:				Male <input type="checkbox"/>	Female <input type="checkbox"/>
GP:					
Easiest contact telephone number:					
Email:					
Dates of Trip					
Date of Departure:					
Return date or overall length of trip:					
Itinerary and purposes of visit					
Country to be visited	Length of Stay	Away from medical help at destination, if so, how remote?			
1.					
2.					
3.					
Please tick as appropriate below to best describe your trip					
1. Type of trip	Business		Pleasure		Other
1. Holiday type	Package		Self organized		Backpacking
	Camping		Cruise Ship		Trekking
3. Accommodation	Hotel		Relatives/ family home		Other
4. Traveling	Alone		With family/friend		In a Group
5. staying in area which is	Urban		Rural		Altitude
6. Planned activities	Safari		Adventure		Other

Personal Medical History
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions, thyroid disorder)
List any current or repeat medications
Do you have any allergies for example to eggs, antibiotics, nuts?
Have you ever had a serious reaction to a vaccine given to you before?
Does having an injection make you feel faint?
Do you or any close family members have epilepsy?
Do you have any history or mental illness including depression or anxiety
Have you recently undergone radiotherapy, chemotherapy, or steroid treatment?
<i>Women only:</i> Are you pregnant or planning pregnancy, or breast feeding?
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?
Please write below any further information which may be relevant

Vaccination History					
Have you ever had any of the following vaccinations/malaria tablets 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					

For discussion when 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:.....

