Travel Risk Assessment Form

If you are travelling in 12 weeks or less, please contact your local travel clinic directly. Not all vaccines are available on the NHS — please refer to travelhealthpro.org.uk for further information.

How to return this form: complete, save and email it to r.quayside@nhs.net before your appointment — we need to receive it in advance, so please don't wait and bring it with you instead. Completing this PDF alone does not send it to us.

Your details

Name *

Date of birth *

Address

Contact number

Gender

Email

Your trip

Country(ies) to be visited *

Date of departure *

Total duration of trip

Where will you mostly be staying? (tick all that apply)

- ☐ City
- ☐ Rural

Type of travel and purpose of trip (tick all that apply)

- ☐ Holiday
- ☐ Business
- ☐ Volunteer / healthcare work
- ☐ Staying in hotel
- ☐ Cruise ship travel
- ☐ Pilgrimage
- ☐ Medical tourism
- ☐ Backpacking
- ☐ Camping / hostels
- ☐ Adventure / diving

Your medical history

For each question, please tick Yes or No, and add any details that might help us.

Are you fit and well today? ○ Yes ○ No

Details (if applicable)

Any allergies, including food, latex or medication ○ Yes ○ No

Details (if applicable)

Tendency to faint with injections ○ Yes ○ No

Details (if applicable)

Any surgical operation in the past, including your spleen or thymus gland removed ○ Yes ○ No

Details (if applicable)

Recent chemotherapy, radiotherapy or organ transplant ○ Yes ○ No

Details (if applicable)

Anaemia, bleeding or clotting disorders, including history of DVT ○ Yes ○ No

Details (if applicable)

Heart disease — angina, irregular heartbeat or high blood pressure ○ Yes ○ No

Details (if applicable)

Diabetes ○ Yes ○ No

Details (if applicable)

Disability ○ Yes ○ No

Details (if applicable)

Epilepsy / seizures ○ Yes ○ No

Details (if applicable)

Gastrointestinal (stomach) complaints ○ Yes ○ No

Details (if applicable)

Liver and/or kidney problems ○ Yes ○ No

Details (if applicable)

HIV / AIDS ○ Yes ○ No

Details (if applicable)

Immune system condition ○ Yes ○ No

Details (if applicable)

Mental health issues — anxiety, depression ○ Yes ○ No

Details (if applicable)

Respiratory (lung) disease, including COPD and asthma ○ Yes ○ No

Details (if applicable)

Rheumatology (joint) conditions ○ Yes ○ No

Details (if applicable)

Spleen problems ○ Yes ○ No

Details (if applicable)

Any other conditions? ○ Yes ○ No

Details (if applicable)

Women only

Are you pregnant? ○ Yes ○ No

Details (if applicable)

Are you breast feeding? ○ Yes ○ No

Details (if applicable)

Are you planning pregnancy while away? ○ Yes ○ No

Details (if applicable)

Current medication

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

Vaccination & malaria tablet history

Please tick any of the following you've had before.

- ☐ Tetanus / polio / diphtheria
- ☐ Typhoid
- ☐ Cholera
- ☐ Meningitis
- ☐ BCG
- ☐ MMR
- ☐ Hepatitis A
- ☐ Rabies
- ☐ Yellow fever
- ☐ Malaria tablets
- ☐ Influenza
- ☐ Hepatitis B
- ☐ Pneumococcal
- ☐ Japanese encephalitis
- ☐ Other

Anything else we should know?

Any additional information

Declaration & signature

Full name (signature) *

Date form signed

Admin use only (staff completes this section)

Please log this form as received in EMIS.

Staff member name	Date logged in EMIS