LAWN MEDICAL CENTRE TRAVEL RISK ASSESSMENT FORM

IN ORDER TO BE ABLE TO PROCESS TRAVEL HEALTH ADVICE AND VACCINES ADMINISTRATION WE REQUEST SUBMISSION OF THIS FORM 6-8 WEEKS PRIOR TO TRAVEL. FAILURE TO DO SO MAY RESULT IN US ADVISING YOU TO ACCESS PRIVATE TRAVEL HEALTH.

Name: Address:	Date of birth: Male □ Female □
E mail:	Telephone number: Mobile number:

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW

Date of departure:	Total length of trip:

COUNTRY TO BE VISITED	EXACT LOCATION OR REGION	CITY OR RURAL	LENGTH OF STAY
1.			
2.			
3.			

Have you taken out travel insurance for this trip?

Do you plan to travel abroad again in the future?

TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY

□ Holiday	□ Staying in hotel	□ Backpacking	Additional information
□ Business trip	□ Cruise ship trip	□ Camping/hostels	
□ Expatriate	□ Safari	□ Adventure	
□ Volunteer work	□ Pilgrimage	□ Diving	
□ Healthcare worker	□ Medical tourism	□ Visiting friends/family	

PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY

	YES	NO	DETAILS
Are you fit and well today			
Any allergies including food, latex, medication			
Severe reaction to a vaccine before			
Tendency to faint with injections			
Any surgical operations in the past, including e.g. your spleen or thymus gland removed			
Recent chemotherapy/radiotherapy/organ transplant			
Anaemia			
Bleeding /clotting disorders (including history of DVT)			
Heart disease (e.g. angina, high blood pressure)			
Diabetes			

Disability			
Epilepsy/seizures			
Gastrointestinal (stomach) complaints			
Liver and or kidney problems			
HIV/AIDS			
Immune system condition			

	YES	NO	DETAILS
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
Women only			
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/polio/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

DATE SUBMITTED: ……. SIGNATURE: …….

PLEASE PHONE THE SURGERY 7 WORKING DAYS AFTER SUBMISSION OF FORM TO CHECK WHAT VACCINATIONS ARE REQUIRED AND BOOK AN APPOINTMENT AS INSTRUCTED.