KINGSTON HEALTH CENTRE

Travel Risk Assessment Form

Name:	Date of Birth:
Email:	Telephone number:
PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW	
Date of Departure:	Total Length of Trip in days:

COUNTRY TO BE VISITED	**EXACT LOCATION OR REGION**	**CITY OR RURAL**	**LENGTH OF STAY (in days)**

TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALLTHAT APPLY			
☐ Holiday ☐ Business trip ☐ Expatriate ☐ Volunteer work ☐ Healthcare worker	☐ Staying in hotel ☐ Cruise ship trip ☐Safari ☐ Pilgrimage ☐ Medial Tourism	☐ Backpacking ☐Camping / Hostels ☐ Adventure ☐ Diving ☐Visiting friends / family	Additional Information

PLEASE SUPPLY DETAILS OF YOUR PERSONAL HSITORY			
	YES	NO	DETAILS
Are you fit and well today			
Any allergies to food, latex, medication			
Severe reaction to a vaccine before			
Tendency to faint with injections			
Any surgical operations in the past, including your spleen or thymus gland removed			
Recent chemotherapy / radiotherapy / organ transplant			
Anaemia			
Bleeding or clotting disorders including a history of DVT			
Heart Disease (e.g. angina)			
Diabetes			
Epilepsy / seizures			
Gastrointestinal (stomach complaints)			
Liver and kidney problems			
HIV / AIDS			
Immune system condition			
Mental health issues (including anxiety / depression)			
Neurological (nervous system illness)			

	YES	NO	DETAILS
Respiratory (lung) disease (asthma / COPD)			
Any other conditions?			
Women only			
Are your pregnant?			
Are you breast feeding?			
Are you planning a pregnancy while away?			

ARE YOU CURRENTLY TAKING ANY MEDICATION (including prescribed, purchased or 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 Bourne Encephalitis	
Yellow Fever		BCG		Other	
Malaria Tablets					
Any additional information					

For Surgery Use Only

☐ Please call patient and advise if they need any vaccinations
☐ Patient has an appointment booked

Date for received:	Date reviewed by Nurse:
Review comments	
☐ Actioned by	Date