

TRAVEL RISK ASSESSMENT FORM – MARDEN MEDICAL CENTRE

Ideally to be completed by traveler **6 to 8 weeks prior to departure**. Please allow the nurse one week to assess your form before you call to book your appointment

If you are submitting your form within 2 weeks of your departure time, we may not have appointments available and you may need to visit a private travel clinic

Name:		Your country of origin:		
		Date of birth:		
		Male <input type="checkbox"/> Female <input type="checkbox"/>		
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				
<input type="checkbox"/> Holiday <input type="checkbox"/> Staying in hotel <input type="checkbox"/> Backpacking <u>Additional information</u>				
<input type="checkbox"/> Business trip <input type="checkbox"/> Cruise ship trip <input type="checkbox"/> Camping/hostels				
<input type="checkbox"/> Expatriate <input type="checkbox"/> Safari <input type="checkbox"/> Adventure				
<input type="checkbox"/> Volunteer work <input type="checkbox"/> Pilgrimage <input type="checkbox"/> Diving				
<input type="checkbox"/> Healthcare worker <input type="checkbox"/> Medical tourism <input type="checkbox"/> 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				

	YES	NO	DETAILS
Liver and or kidney problems			
HIV/AIDS			
Immune system condition			
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?			
Have you undergone FGM / been cut / circumcised			

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

Please refer to TRAVEL HEALTH PRO and Jane Chiodini web sites prior to your appointment.

Travel risk assessment form devised by Jane Chiodini © 2012 in conjunction with resources below.

1. Chiodini J, Boyne L, Grieve S, Jordan A. (2007) *Competencies: An Integrated Career and Competency Framework for Nurses in Travel Health Medicine*. RCN, London.
2. Field VK, Ford L, Hill DR, eds. (2010) *Health Information for Overseas Travel*. National Travel Health Network and Centre, London, UK.