**Coulby Medical Practice**

Cropton Way, Coulby Newham

Middlesbrough TS8 0TL

Tel: (01642) 045830

**TRAVEL RISK ASSESSMENT FORM**

**Complete before appointment – email to coulby.mp@nhs.net**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TRAVELLER - PATIENT DETAILS** | | | | | | | | | | | | |
| Name: | | | | Date of Birth: | | | | | | | | |
| Telephone Number/s: | | | | Your country of origin: | | | | | | | | |
| Address: | | | | | | | | | | | | |
| **INFORMATION ABOUT YOUR TRIP** | | | | | | | | | | | | |
| 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?  Yes  No | | | | | | | | | | | | |
| Do you plan to travel abroad again in the future?  Yes  No | | | | | | | | | | | | |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY** | | | | | | | | | | | | |
| Holiday Staying in hotel Backpacking  Business trip Cruise ship trip Camping/hostels  Expatriate Safari Adventure  Volunteer work Pilgrimage Diving  Healthcare worker Medical tourism Visiting friends/family | | | | | | | | | Additional Information | | | | |
| **DETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | | | | | | | | | | |
|  | | | | | **YES** | | **NO** | | **Additional Details** | | | |
| Are you fit and well today? | | | | |  | |  | |  | | | |
| Do you have any allergies e.g. food, latex, medication? | | | | |  | |  | |  | | | |
| Have you ever had a severe vaccine reaction? | | | | |  | |  | |  | | | |
| Do you tend to faint with injections? | | | | |  | |  | |  | | | |
| Have you had any surgical operations in the past, including e.g. your spleen or thymus gland removed? | | | | |  | |  | |  | | | |
| Have you recently had chemotherapy, radiotherapy, or an organ transplant? | | | | |  | |  | |  | | | |
| **Do you have any history of…** | | | | | | | | | | | | |
| 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? | | | | |  | |  | |  | | | |
| 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 | | | | |  | |  | |  | | | |
| **INFORMATION ON ANY PAST ROUTINE, OR TRAVEL, VACCINATIONS** | | | | | | | | | | | | |
| Diphtheria/Tetanus/Polio |  | | MMR | | |  | | | | Influenza | |  |
| Typhoid |  | | Hepatitis A | | |  | | | | Pneumococcal | |  |
| Cholera |  | | Hepatitis B | | |  | | | | Meningitis | |  |
| Rabies |  | | Japanese  encephalitis | | |  | | | | Tick borne  encephalitis | |  |
| Yellow fever |  | | BCG | | |  | | | |  | | |
| Malaria Tablets - | | | | | | | | | | | | |
| Other - | | | | | | | | | | | | |