FOWEY RIVER PRACTICE

TRAVEL RISK ASSESSMENT FORM

PLEASE COMPLETE THIS FORM PRIOR TO ATTENDING FOR YOUR TRAVEL CONSULTATION

NAME DOB TEL. NO.

DATES OF TRIP

Date of departure Return date or overall duration of trip

ITINARY AND PURPOSE OF TRIP

Country to be visited

Length of stay in each area/country

PLEASE CIRCLE THE DESCRIPTIONS THAT BEST DESCRIBE YOUR TRIP

Business	Pleasure	Other
Package	Camping	Self organised
Cruise ship	Backpacking	Trekking
Hotel	Relatives/family home	Other
Urban	Rural	Altitude
Safari	Adventure	Other activities

PERSONAL MEDICAL HISTORY

Do you have any recent or past medical history of note? Including diabetes, epilepsy, heart or lung conditions?

List any current or repeat medications

Do you have any allergies eg antibiotics, medicines, nuts, eggs?

Have you ever had a serious reaction to a vaccine in the past?

Do you have any history of mental illness, including anxiety or depression ?

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Have you (in the past month) had any other vaccinations?

Are you pregnant or planning pregnancy or breast feeding?

Any other information that may be relevant to this trip?

Vaccination history

Have you had any of the following vaccinations or malaria tablets, if so, when?

Tetanus

Polio

Diptheria

Typhoid

Hepatitis A

Hepatitis B

Meningitis

Yellow Fever

Influenza

Rabies

Japanese B Encephalitis

Tick Borne

Malaria Tablets

Other