King Street Surgery

Travel risk assessment form

Please return this completed travel vaccination risk assessment form, 8 WEEKS prior to your travel date.

This will allow the nurses to carry out a full assessment of your vaccination needs and ensure any vaccinations needed are given in time to maximise your levels of immunity before your departure date. Our practice nurses will then contact you by phone (2 attempts will be made) if we are unable to make contact a message will be left and you will then need to ring the nurses back.

PLEASE COMPLETE THIS IN AS MUCH DETAIL AS POSSIBLE

Personal information:

Name:	
D.O.B:	
Sex:	Male/Female
Address:	

Contact details:

Telephone:	Home:	Mobile:	Work:
Can a message be left?:	Yes/No	Yes/No	Yes/No

Information about your trip, please give us as much information as possible:

Date of departure:	
Return date:	

Country	Order of stay	Exact location or region	City/rural	Length of stay.

Please continue on separate sheet if necessary.

Type of travel and purpose of trip - please tick all that apply:

Holiday		Backpacking	
Business trip		Camping/Hostels	
Expatriate		Adventure	
Volunteer work		Diving	
Healthcare worker		Visiting friends/family	
Staying in a hotel		Safari	
Cruise ship travel		Pilgrimage	

Additional information: activities/as much information about your holiday as possible.

Personal medical history.

Any allergies	Yes/No	
Severe reaction to vaccines before?	Yes/No	
Tendency to faint with injections?	Yes/No	
Any surgery in the past?	Yes/No	
Recent chemo/radiotherapy?	Yes/No	
Anaemia	Yes/No	
Bleeding/clotting disorders? (DVT)	Yes/No	
Heart disease (e.g. angina, high blood pressure)	Yes/No	
Diabetes	Yes/No	
Disability	Yes/No	
Epilepsy/seizures	Yes/No	
Gastrointestinal (stomach) complaints	Yes/No	
Liver and or Kidney problems	Yes/No	
HIV/AIDS	Yes/No	
Immune system conditions	Yes/No	
Mental health issues (including anxiety,depression)	Yes/No	
Neurological (nervous system) illness	Yes/No	
Respiratory (Lung) disease	Yes/No	
Rheumatology (joint) conditions	Yes/No	
Spleen problems	Yes/No	
Any other conditions	Yes/No	

Women only

Are you pregnant?	Yes/No	
Are you breast feeding?	Yes/No	
Are you planning pregnancy while away?	Yes/No	

Medication:

Are you currently taking any medication? (including prescribed, purchased or a contraceptive pill)

Please write below any further information which may be relevant.

Vaccination history:

Have you ever had any of the following vaccinations/malaria tablets and if so when?

	Date received		Date received
Diptheria		Rabies	
Tetanus		Yellow fever	
Polio		Jap B Enceph	
Typhoid		Meningitis ACWY	
Hepatitis A		Other	
Hepatitis B			