Billingshurst Surgery Travel Risk Assessment Form

Please complete this form prior to your travel and return it to reception. You will be phoned to arrange an appointment.

Personal details

Name:

Date of Birth: Male [ ] Female [ ]

Easiest contact telephone number: E.mail:

Dates of trip

Date of departure: Return date or overall length of trip:

Itinerary and purpose of visit

Country to be visited	Length of stay	Away from medical help at destination? If so, how remote?
1.		
2.		
3.		

Please circle the descriptions that best describe your trip

1.	**Type of trip:**	Business	Pleasure	Other
2.	**Holiday type:**	Package Camping	Self-organised Cruise ship	Backpacking Trekking
3.	**Accommodation:**	Hotel	Relatives/family home	Other
4.	**Travelling:**	Alone	With family/friend	In a group
5.	**Staying in area which is:**	Urban	Rural	Altitude
6.	**Planned activities:**	Safari	Adventure	Other

Personal medical history

Do you have any recent or past medical history of note? This includes diabetes, heart or lung conditions.

List any current or repeat medications.

Do you have any allergies, for example to eggs, antibiotics, nuts?

Have you ever had a serious reaction to a vaccine given to you before?

Does having an injection make you feel faint?

Do you or any close family members have epilepsy?

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

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Have you (in the last month) had any other vaccination?

Do you have a Thymus disorder – including Thymoma, Thymectomy, Myasthenia Gravis or Di George Syndrome?

Women only: Are you pregnant or planning pregnancy or breast feeding?

Have you taken out travel insurance, and if you have a medical condition, informed the insurance company?

Please give any further information that may be relevant, including any future travel plans.

Vaccination history

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

Tetanus	☐	Polio	☐	Diphtheria	☐
Typhoid	☐	Hepatitis A	☐	Hepatitis B	☐
Meningitis	☐	Yellow Fever	☐	Influenza	☐
Rabies	☐	Jap B Enceph	☐	Tick Borne	☐
Malaria tablets	☐	Other	☐		

Name of 'other' vaccines:

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I have been advised that may be charged a fee for some of these vaccinations. I consent to the vaccines being given.

Signed: Date: