

# NEWTON'S



# PRACTICE

**TRAVEL RISK ASSESSMENT FORM** – ideally to be completed by traveller prior to appointment.

Name:		Date of birth	
Male <input type="checkbox"/> Female <input type="checkbox"/>			
E mail:		Telephone number:	
		Mobile number:	
<b>PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW</b>			
Date of departure:		Total length of trip:	
<b>COUNTRY TO BE VISITED</b>	<b>EXACT LOCATION OR REGION</b>	<b>CITY OR RURAL</b>	<b>LENGTH OF STAY</b>
1.			
2.			
3.			
Have you taken out travel insurance for this trip? Do you plan to travel abroad again in the future?			
<b>TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY</b>			
<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	
<b>PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY</b>			
	<b>YES</b>	<b>NO</b>	<b>DETAILS</b>
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			
Liver and or kidney problems			
HIV/AIDS			
Immune system condition			

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	YES	NO	DETAILS
Mental health issues (including anxiety, depression)			
Neurological (nervous system) illness			
Respiratory (lung) disease			
Rheumatology (joint) conditions			
Spleen problems			
Any other conditions?			
<b>Women only</b>			
Are you pregnant?			
Are you breast feeding?			
Are you planning pregnancy while away?			

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

<b>PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST</b>					
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**