HAWKESLEY MEDICAL PRACTICE

TRAVEL HEALTH ASSESSMENT FORM –this form must be completed and returned to us

*6 weeks before* your departure date. You will be contacted if an appointment is necessary.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name:  Address: | | Date of birth: | | | | | |
| Male □ Female □ | | | | | |
| E mail: | | Telephone number:  Mobile number: | | | | | |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW** | | | | | | | |
| 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? Do you plan to travel abroad again in the future? | | | | | | | |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY** | | | | | | | |
| * Holiday □ Staying in hotel □ Backpacking Additional information * Business trip □ Cruise ship trip □ Camping/hostels * Expatriate □ Safari □ Adventure * Volunteer work □ Pilgrimage □ Diving * Healthcare worker □ Medical tourism □ Visiting friends/family | | | | | | | |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | | | | | |
|  | | | **YES** | **NO** | | **DETAILS** | |
| 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 | | |  |  | |  | |
| Anemia | | |  |  | |  | |
| 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 | | |  |  | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| 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 / circumcised |  |  |  |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** | | | | | |
| 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:**

Please return your completed form to: Hawkesley Medical Practice, alternatively you can fax: 01214864201 or email: [hawkesleymedical.practice@nhs.net](mailto:hawkesleymedical.practice@nhs.net)

*FOR THE NURSE TO COMPLETE ONLY*

|  |  |
| --- | --- |
| *Vaccinations needed:* | *Completed / date:* |
|  |  |
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|  |  |