Travel Risk Assessment Form

Carnforth Pharmacy+

*Please email the completed form to **info@carnforthpharmacy.co.uk***

Name:

Date of birth:

Address:

Telephone:

Email:

GP surgery:

Travel details

Departure date:

Total length of trip:

Return date:

Country	Destination(s) within the country	Length of stay	Mode of transport

Destination description - tick all that apply

Urban (town/city)
Jungle
Coastal
Safari
Rural (countryside)
Desert
High altitude
Other (please specify)

Purpose of trip - tick all that apply

Adventure/gap year
Diving
Health worker
Other (please specify)
Cruise
Medical treatment
Pilgrimage
Long term/expatriate
Business/work
Holiday
Aid work/emergency response
Visiting friends and family
Charity/volunteer

Destination description - tick all that apply

Hotel
Hostel
Other (please specify)
Camping
Staying with family/friends

Do you have travel health insurance (covering pre-existing health conditions and planned activities if relevant)? YES NO

Medical history

Please tick either YES or NO.

Are you well? YES NO

Question		
Do you have any health conditions? *e.g diabetes, respiratory (breathing) problems, heart disease, neurological illness, liver or kidney problems, blood disorders (e.g. sickle cell disease, clotting or bleeding issues)*	YES	NO
Do you, or a first degree relative (parents, sibling or child), have epilepsy or seizures?	YES	NO
Have you ever experienced any mental health issues, even mild anxiety, or depression?	YES	NO
Do you have, or have had, a condition that could impair your immune system? *e.g. HIV/AIDS, blood cancer*	YES	NO
In the last 12 months, have you taken any medication or had treatment that could impair your immune system? *e.g. chemotherapy, radiotherapy, steroid tablets*	YES	NO
Have you ever had any surgery? *e.g. open-heart surgery, transplant surgery, spleen or thymus gland removal*	YES	NO
Have you ever had a travel related illness/injury that required assessment/treatment in hospital?	YES	NO
Are you receiving regular treatment or follow up with your GP/hospital specialist?	YES	NO
Do you have any disability or mobility problems?	YES	NO
Do you have any allergies? *e.g. food, medication or latex*	YES	NO
Have you, or anyone in your family, ever had a severe reaction to a vaccine or malaria medication?	YES	NO
Are you or your partner pregnant or planning pregnancy?	YES	NO
Are you breast feeding?	YES	NO
Do you have known or suspected cancers, or have you had cancer in the past?	YES	NO
Have you received any live vaccines in the last 4 weeks?	YES	NO
Have you received any antibiotics in the last 14 days?	YES	NO

Further Details

If you answered yes to any of the above questions, please provide details here with any other important information regarding your health, including problems experienced with previous travel:

Medication

Please give details of any medication you are taking, including prescribed/self-treatment/over-the-counter remedies and contraception.

Name of medication	Dose/frequency

Under 18s only

Weight: Date:

Vaccine history

If you have received vaccinations elsewhere which will not be in our clinic records, please provide details here;

Vaccination	Date(s) of vaccination	Date(s) of vaccination unknown	Notes
Cholera			
Dengue Fever			
Diptheria/Tetanus/Polio			
Hepatitis A			
Hepatitis A/B			
Hepatitis A/Typhoid			
Hepatitis B			
Japanese encephalitis			
Meningitis ACWY			
MMR			
Rabies			
Tick-borne encephalitis			
Turberculosis			
Typhoid			
Yellow fever			
Other			

Where did you hear about us?

Please tick any of the boxes that apply.

Friend	GP surgery	Internet search	Trustpilot
Magazine	Pharmacy window	Our website	Other (please specify)

Thank you for completing the form.

Please email the completed form to ***info@carnforthpharmacy.co.uk***