

# 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:

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Date of Birth:

Male [ ] Female [ ]

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Easiest contact telephone number:

E.mail:

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## 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.

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2.

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3.

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## Please circle the descriptions that best describe your trip

1. **Type of trip:** Business Pleasure Other

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2. **Holiday type:** Package Camping Self-organised Cruise ship Backpacking Trekking

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3. **Accommodation:** Hotel Relatives/family home Other

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4. **Travelling:** Alone With family/friend In a group

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5. **Staying in area which is:** Urban Rural Altitude

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6. **Planned activities:** Safari Adventure Other

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## Personal medical history

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

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List any current or repeat medications.

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

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

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Does having an injection make you feel faint?

Do you or any close family members have epilepsy?

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

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Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

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

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

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

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

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

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### Vaccination history

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

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|                 |                          |              |                          |             |                          |
|-----------------|--------------------------|--------------|--------------------------|-------------|--------------------------|
| Tetanus         | <input type="checkbox"/> | Polio        | <input type="checkbox"/> | Diphtheria  | <input type="checkbox"/> |
| Typhoid         | <input type="checkbox"/> | Hepatitis A  | <input type="checkbox"/> | Hepatitis B | <input type="checkbox"/> |
| Meningitis      | <input type="checkbox"/> | Yellow Fever | <input type="checkbox"/> | Influenza   | <input type="checkbox"/> |
| Rabies          | <input type="checkbox"/> | Jap B Enceph | <input type="checkbox"/> | Tick Borne  | <input type="checkbox"/> |
| Malaria tablets | <input type="checkbox"/> | Other        | <input type="checkbox"/> |             |                          |

Name of 'other' vaccines:

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### 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: