IMPERIAL COLLEGE HEALTH CENTRE

TRAVEL RISK ASSESSMENT FORM

Office use only
EMIS number
……………..

Please complete ALL SECTIONS in BLOCK CAPITALS

PERSONAL DETAILS

1 Family Name …………………………………………………..….. 5 Date of Birth ☐☐ | ☐☐ | ☐☐☐☐ (day / month / year)

2 Forenames …………………………………………………..….. 6 Sex ☐ Male ☐ Female

3 Contact Tel …………………………………………………..…..

4 Email ………………………………………………………………………………………..…..

DATES OF TRAVEL

7 Date of Departure from UK ☐☐ | ☐☐ | ☐☐☐☐ (day / month / year)

8 Date of Return to UK ☐☐ | ☐☐ | ☐☐☐☐ (day / month / year)
OR
Overall length of trip ……………………………….

9 TRAVEL ITINERARY

	Country to be visited	Length of stay	Will you be away from access to medical help? If so how remote is the area ?
1.			
2.			
3.			

PURPOSE OF TRAVEL Please tick as many as appropriate to best describe your trip.

10 **Type of trip** ☐ Business ☐ Pleasure ☐ Other ……………………………..……

11 **Holiday type** ☐ Package ☐ Self-organised

☐ Backpacking ☐ Trekking ☐ Camping ☐ Cruise

12 **Accommodation** ☐ Hotel ☐ Relatives/ family home ☐ Other ……………………………………..

13 **Travelling** ☐ Alone ☐ With family/friend ☐ Other …………………………………....

14 **Destination** ☐ Urban ☐ Rural ☐ Altitude

15 **Activities** ☐ Safari ☐ Adventure ☐ Other ……………………………………..

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16Family Name …………………………… 17Forename ……………………………… 18Date of Birth [day | month | year]

19**MEDICAL HISTORY** Please tick if you have ever suffered from any of the following problems

- ☐ Anxiety, depression or stress
- ☐ Diabetes
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Heart, lung or kidney disease
- ☐ Hepatitis or liver disease
- ☐ Mental illness
- ☐ Stroke
- ☐ Tuberculosis

20Please give details of any other past medical history of note.

………

………

21**CURRENT MEDICATION** (Including contraceptive pills and over the counter treatments)

………

………

22**ALLERGIES** (e.g. drugs, eggs, nuts)

………

FURTHER INFORMATION

23Have you ever had a serious reaction to a vaccine given to you before?	☐ Yes	☐ No
24Does having an injection make you feel faint?	☐ Yes	☐ No
25Have you recently undergone radiotherapy, chemotherapy or steroid treatment?	☐ Yes	☐ No
26Do any of your close family have epilepsy?	☐ Yes	☐ No
27Are you pregnant or planning pregnancy, or breast feeding?	☐ Yes	☐ No
28Have you taken out travel insurance?	☐ Yes	☐ No
29If you have a medical condition, have you informed the insurance company?	☐ Yes	☐ No
30Have you ever taken anti-malarial tablets before?	☐ Yes	☐ No

PLEASE NOTE

- **Please arrive at least 10 minutes before your travel clinic appointment time**
- **It is essential that you bring this completed form with you to your appointment**
- **Please bring with you any record you have of your previous vaccinations**
- **Your travel clinic appointment is FREE. However please be aware that there are charges for some travel services.**
- **All charges must be paid at the time of vaccination, by cheque supported with cheque guarantee card. We cannot accept card payments.**

Please see our website for more information.

Please do NOT complete this section until your appointment.

I have no reason to think that I am pregnant. I have received information on the risks and benefits of the vaccinations and treatments recommended, and have had the opportunity to ask questions.
I consent to these vaccinations being given.

Signature .... **Date** [day | month | year]

Please do NOT complete this section until your appointment.

Updated 4/08 DH