**BARNTON PHARMACY TRAVEL HEALTH RISK ASSESSMENT FORM 2023**

**Please complete one form per person attending and bring it to your appointment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | Your country of origin: | | | | |
| Address:  Post Code: | | | E mail: | | | | |
| Mobile number: | | | | |
| Date of birth: | | Age: | GP surgery: | | | | |
| **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/ RURAL)**  **CITY OR RURAL** | | | | | | **LENGTH OF STAY** |
| 1.  2.  3.  4. |  | | | | | |  |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP (Work, Friends and Family, Backpacking, 5\*accommodation) etc)** | | | | | | | |
|  | | | | | | | |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY.** Please provide details or write NONE | | | | | | | |
| Do you feel unwell or have a fever today? | | | | | | | |
| Medical conditions: | | | | | | | |
| Medications: | | | | | | | |
| Allergies (ie eggs, antibiotics, latex): | | | | | | | |
| Any Issues which affect your immune system? (ie medications, treatments, myasthenia gravis, HIV): | | | | | | | |
| Past or recent surgery (especially spleen or thymus) | | | | | | | |
| In last 12 months have you taken steroids, anti-cancer drugs, blocking therapy, radiotherapy or chemotherapy? | | | | **YES** | **NO** | **DETAILS** | |
| Have you ever had cancer, leukaemia, lymphoma, organ/ bone marrow transplant? | | | |  |  |  | |
| Have you ever had a serious (anaphylactic reaction to any previous vaccine? | | | |  |  |
| Do you have a tendency to faint with injections? | | | |  |  |
| Do you or any close family member suffer from epilepsy? | | | |  |  |
| Have you or any close family member suffered from DVT (deep vein thrombosis) | | | |  |  |
| Do you have any history of mental illness including anxiety or depression? | | | |  |  |
| Are you pregnant or breastfeeding or planning pregnancy? | | | |  |  |
| Have you informed your travel insurance of medical conditions you have? | | | |  |  |

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| **What vaccinations / medication have you had before? Include dates if known.** | | | | | |
| Have you had full childhood Vaccine courses?  **Is there anything else important in medical health/ past vaccine history?** | | | | | |
| **Hepatitis A** | 1  2  3 | **Japanese**  **encephalitis** | 1  2  3 | **Tick borne**  **encephalitis** | 1 |
| 2 |
| 3 |
| **Tetanus/polio/ diphtheria** |  | **Cholera** |  | **Yellow fever** |  |
| **Typhoid** |  | **Meningitis ACWY** |  | **Other** |  |
| **Rabies** | 1  2  3 | **Hepatitis B** | 1  2  3 |
| Malaria Tablets previously? | | | | | |
|  | | | | | |

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| **The information I have provided is true and to the best of my knowledge**  **Signed: Parent/parent/guardian Date:**  **Risk assessment carried out by HCP: Print: Sign: Date:** |