Granta Medical Practices
Travel risk assessment (form A) – to be completed by traveller prior to appointment.

Name:		Date of Birth
Address:		□ Male □ Female Telephone Number: (Can we leave a message?) Yes No
Email:		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 Info
□ Business trip	□ Cruise ship trip	□ Camping/hostels	
□ Expatriate	□ Safari	□ Adventure	
□ Voluteer work	□ Pilgrimage	□ Diving	
□ Healthcare worker	□ Medical tourism	□ Visiting friend/family	

Please supply details of your personal medical history

	Yes	**No**	**Details**
Smoking Status			Never Smoked Smoker Ex smoker
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			
Anaemia			
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			
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?			

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

Please supply information on any vaccines or malaria tablets taken in the past

Tetanus/polio/diphtheria	MMR	Influenza
Typhoid	Hepatitis A	Pneumoclccal
Cholera	Hepatitis B	Menigitis
Rabies	Japanese Encephalitis	Tick Borne Encephalitis
Yellow fever	BCG	Other
Malaria Tablets		

Any additional information:

Patients signature:	Date:

For Office Use ONLY:

Length of appointment for first appointment:	
Date & Time of first appointment:	
Nurse:	
Receptionist:	`