



Addingham Medical Centre 151a Main Street Addingham LS29 0LZ
 T: 01943 830367 w. www.thevaccineclinic.co.uk

Travel Health Risk Assessment Form

To enable us to make a full risk assessment for your trip it is crucial that you complete this form and bring it with you to your appointment.

Personal details

*please delete as appropriate

Surname:First name:

Date of birth: * Male * Female

Address.....

Contact telephone number:

Email address:.....

Dates of trip

Date of departure:..... Return date:

Itinerary and purpose of trip

Country(s) to be visited	Length of stay	Away from medical help at destination? If so, how remote?
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Please tick the descriptions that best describes your trip

Type of Trip	Business	Pleasure	Other
Holiday type	Package	Self-organised	Backpacking
	Camping	Cruise ship	Visiting family/friends
	Other		
Accommodation	Hotel	Relatives/family home	Other
Travelling	Alone	With family/friend	In a group
Area which is	Urban	Rural	Altitude
Planned activities	Safari	Adventure	Other



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Personal medical history

Do you have any current or past medical history of note? This includes diabetes, heart or lung conditions, thymus disorder, mental health problems *Yes *No

If yes please give details:

.....

List any current or repeat medications including contraceptive pill.

.....

Are you allergic to or have you reacted badly to medicines, antibiotics, eggs or previous vaccines? *Yes *No

If yes please give details.

Does having an injection make you feel faint? *Yes *No

Have you undergone radiotherapy, chemotherapy or steroid treatment? *Yes *No

If yes please give details.

Women only: Are you pregnant or planning pregnancy or breast-feeding? *Yes *No

If yes please give details.

Have you taken out medical insurance? If you have a medical condition, have you informed the insurance company about this? *Yes *No

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

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Vaccination history

Have you ever had any of the following vaccinations/malaria tablets, and if so when? List all relevant dates.

	Date(s)		Date(s)		Date(s)
Diphtheria		Hepatitis A		Hepatitis B	
Influenza		Japanese Encephalitis		Malaria tablets	
Meningitis ACWY		Polio		Rabies	
Tick Encephalitis		Tetanus		Typhoid	
Yellow Fever		Other			

Please remember to bring this completed form along with any other immunisation records you may have to your appointment.