**Belgrave Medical Centre**

**Travel Risk Assessment Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | | Date of birth: | | | |
| Male  Female | | | |
| Email: | | Telephone number: | | | |
| Mobile number: | | | |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP:** | | | | | |
| Date of departure: | | Total length of trip: | | | |
| Country to be visited | Exact location/region | City or rural | | | Length of stay |
| 1. |  |  | | |  |
| 2. |  |  | | |  |
| 3. |  |  | | |  |
| 4. |  |  | | |  |
| 5. |  |  | | |  |
| Type of travel and purpose of this trip – please tick all that apply  Holiday  Staying in hotel  Back packing  Business trip  Cruise ship  Camping/hostels  Expatriate  Safari  Adventure  Volunteer work  Pilgrimage  Diving  Healthcare worker  Medical tourism  Visit friends/family | | | | | |
| Have you taken out insurance for this trip? | | YES | NO |  | |
| Do you plan to travel abroad again in the future? | | YES | NO | DETAILS | |
| **WOMEN ONLY PLEASE ANSWER EACH QUESTION** | | | | | |
| Are you pregnant | | YES | | NO | |
| Are you breastfeeding | | YES | | NO | |
| Are you planning a pregnancy whilst away | | YES | | NO | |
| **PLEASE LIST ANY MEDICAL CONDITIONS OR ALLERGIES WHICH YOU HAVE** | | | | | |
|  | | | | | |
| **PLEASE SUPPLY DETAILS OF ANY MEDICATIONS YOU ARE TAKING WHICH ARE NOT PRESCRIBED BY US HERE AT THE SURGERY** | | | | | |
|  | | | | | |
| **PLEASE NOTE ANY OTHER INFORMATION YOU WISH US TO BE AWARE OF BELOW** | | | | | |
|  | | | | | |
| **CURRENT HEALTH** | | | | | |
| Are you fit and well today? | | YES | | NO | |
| If No, please give further details | | | | | |