**Travel Risk Assessment Form – To be completed and returned prior to appointment**

**Palatine Group Practice, Isle of Man**

**Please write clearly**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | | | |
| Name: DOB: M/F | | | | | | |
| **Contact Number:**  **Landline: Mobile:**  I consent to receiving text messages from the surgery YES / NO (Please circle) | | | | | | |
| **Email address:**  I consent to receiving email messages from the surgery YES / NO (Please circle) | | | | | | |
| **Please supply information about your trip below, including airports transfers:** | | | | | | |
| **Date of Departure of Island:** | | | | **Date of Return to Island:** | | |
| **Country visiting** | | **Exact location / region** | | **City / Rural** | **Exact dates** | |
|  | |  | |  |  | |
|  | |  | |  |  | |
|  | |  | |  |  | |
|  | |  | |  |  | |
|  | |  | |  |  | |
| **Have you taken out appropriate insurance?** | | | | | | |
| **Does this include repatriation to the Isle of Man?** | | | | | | |
| **Type of Travel:**  **Holiday Staying in hotel Backpacking**  **Business Trip  Safari Camping / Hostel**  **Expatriate  Pilgrimage Adventure**  **Volunteer Work  Diving**  **Healthcare Worker Visiting Family / Friends** | | | | | | |
| **Please Supply details of your medical history:** | | | | | | |
|  | | **Yes:** | | **No:** | **Details:** | |
| **Food Allergy:** | |  | |  |  | |
| **Medication Allergy:** | |  | |  |  | |
| **Latex Allergy:** | |  | |  |  | |
| **Medication:** | |  | |  |  | |
| **Surgical procedures, including removal of spleen, thymus gland removed:** | |  | |  |  | |
| **Recent Chemotherapy/radiotherapy/organ transplant:**  **Immunocompromised?** | |  | |  |  | |
| **Any long term conditions?**  **Asthma or COPD**  **Diabetes**  **Heart disease**  **Epilepsy**  **HIV/AIDS** | |  | |  |  | |
| **Any history of stroke or blood clots?** | |  | |  |  | |
| **Gastrointestinal (stomach) complaints** | |  | |  |  | |
| **Rheumatology concerns** | |  | |  |  | |
| **Neurological illness** | |  | |  |  | |
| **Mental Health Issues** | |  | |  |  | |
| **Women only:** | | | | | | |
| **Are you pregnant?**    **Are you breast feeding** |  | |  | | |  |
| **Are you planning pregnancy within the next 3 months post travel?** |  | |  | | |  |

**Are you taking any prescribed medication, over the counter, privately prescribed, recreational or herbal?**

|  |
| --- |
|  |

**Any additional Information:**

|  |
| --- |
|  |