**PRE-TRAVEL RISK ASSESSMENT FORM**

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| TRAVELER NAME | GENDER | DATE OF BIRTH | DATE OF DEPARTURE | DATE OF RETURN |
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| WILL YOU BE TRAVELING ALONE OR IN A GROUP? | |  |
| PURPOSE OF TRAVEL |  | |
| WHAT ACTIVITIES OR EXCURSIONS DO YOU HAVE PLANNED? |  | |

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| **DESTINATION / AREA OF TRAVEL**  in order of visit | **DURATION OF STAY** | **LIVING ACCOMMODATION**  e.g. hotel, hostel, tent, family home | **MODE(S) OF TRANSPORTATION** |
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| MEDICAL HISTORY | |
| **MEDICAL CONDITION(S)**  current and previous |  |
| **CURRENT MEDICATION(S)**  please list dosage and frequency |  |
| **ALLERGIES**  if any |  |
| **REACTIONS TO PREVIOUS VACCINES**  if any |  |
| **Have you recently had surgery?** |  |
| **Have you previously taken malaria tablets?**  If so, please list the name of each. |  |
| **Please add any additional information you feel is relevant.** |  |

Prior to making an appointment, please submit completed form to:

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Please allow 48 hours after submitting this form to call to make an appointment at our office.

Remember to bring an updated record of any vaccinations you have received to your appointmenta