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| --- | --- |
| Full Name: | Your Country of Origin: |
| Email Address: | Date of Birth: |
| Contact Number | Gender Male [ ]  Female [ ]  |

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| **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? Yes [ ]  No [ ]  |
| Do you plan to travel abroad again in the future? Yes [ ]  No [ ]  |

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| **Type of Travel and Purpose of Trip** –Please tick all that apply |
| [ ]  Holiday[ ]  Business Trip[ ]  Expatriate[ ]  Volunteer Work[ ]  Healthcare Worker | [ ]  Staying in hotel[ ]  Cruise Ship Trip[ ]  Safari[ ]  Pilgrimage[ ]  Medical Tourism | [ ]  Backpacking[ ]  Camping/Hostels[ ]  Adventure[ ]  Diving[ ]  Visiting friends/Family | **Additional Information** |

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| **Are you currently taking any medication?** *(Including prescribed, purchased, or contraceptive pill)* |
| If yes, please detail below: |

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| **Please supply information of any vaccine or malaria tablets taken in the past** |
| Tetanus/Polio/Diptheria |[ ]  MMR |[ ]  Influenza |[ ]
| Typhoid |[ ]  Hepatitis A |[ ]  Pneumococcal |[ ]
| Cholera |[ ]  Hepatitis B |[ ]  Meningitis |[ ]
| Rabies |[ ]  Japanese Encephalitis |[ ]  Tick Borne Encephalitis |[ ]
| Yellow Fever |[ ]  BCG |[ ]  Malaria Tablets |[ ]
| Other (Please specify) |  |

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| **Please Supply Details of Your Personal Medical History** |
| **Question** | **Yes** | **No** | **Details** |
| Are you fit and well today? |  |  |  |
| Any allergies including, food, Latex or Medication? |  |  |  |
| Severe reaction to a vaccine before? |  |  |  |
| Tendency to faint wth injections? |  |  |  |
| Any surgical operation in the past, including e.g., your spleen or thymus gland removal? |  |  |  |
| Recent chemotherapy/Radiotherapy/Organ Transplant |  |  |  |
| Anemia |  |  |  |
| 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 not listed above? |  |  |  |

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| **Female Specific Questions** | **Yes** | **No** | **Details** |
| Are you pregnant |  |  |  |
| Are you breast feeding |  |  |  |
| Are you planning pregnancy while away |  |  |  |
| Have you undergone FGH/Been Cut/Circumcised |  |  |  |

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| **Any Additional Information** |
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| Office Use Only |
| Form Completed |  | Appointment Booked |  | Scanned to Record |  |