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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: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 |  |