|  |  |
| --- | --- |
| Name:Address: | Your country of origin: |
| Date of birth: |
| Male

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|  |

Female

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|  |

 | Telephone number:Mobile number: |
| Email:  |
| **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?Do you plan to travel abroad in the future? |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE TICK ALL THAT APPLY** |
|  Holiday Staying in hotel Backpacking   Business trip Cruise ship trip Camping/Hostel Expatriate Safari Adventure Volunteer work Pilgrimage Diving Healthcare worker Medical tourism Visiting friends/Family |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** |
|  | **YES** | **NO** | **DETAILS** |
| Are you fit and well today |  |  |  |
| Any allergies including food, latex, medication |  |  |  |
| Severe reaction to a vaccine before |  |  |  |
| Tendency to faint with injections |  |  |  |
| Any surgical operations in the past, including spleen or thymus gland |  |  |  |
| Recent Chemotherapy/Radiotherapy/Organ transplant |  |  |  |
| Anaemia |  |  |  |
| Bleeding/Clotting disorders (including history of DVT) |  |  |  |
| Heart disease (e.g. Angina, high blood pressure |  |  |  |
| Diabetes |  |  |  |
| Disability |  |  |  |
| Epilepsy/Seizures |  |  |  |
|  | **YES** | **NO** | **DETAILS** |
| 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? |  |  |  |
| **Women only** |
| Are you pregnant? |  |  |  |
| Are you breastfeeding? |  |  |  |
| Are you planning pregnancy while away |  |  |  |
| Have you undergone FGM/been cut/circumcised |  |  |  |

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| **Are you currently taking any medication** (including prescribed, purchased or contraceptive pill)? |
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| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** |
| Tetanus/Polio/Diphtheria |  | MMR |  | Influenza |  |
| Typhoid |  | Hepatitis A |  | Pneumococcal |  |
| Cholera |  | Hepatitis B |  | Meningitis |  |
| Rabies |  | Japanese encephalitis |  | Tick borne encephalitis |  |
| Yellow fever |  | BCG |  | other |  |

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| **Any additional information** |