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

|  |
| --- |
| **Are you currently taking any medication** (including prescribed, purchased or contraceptive pill)? |
|  |

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

|  |
| --- |
| **Any additional information** |