|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | Address: | | | | | | | | | |
| Date of birth: | | | | | | | | | |
| Male □ Female □ | | | | | | | | | |
| E mail: | | | Telephone number:  Mobile number: | | | | | | | | | |
| **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 again in the future? | | | | | | | | | | | | |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP - PLEASE TICK ALL THAT APPLY** | | | | | | | | | | | | |
| □ Holiday □ Staying in hotel □ Backpacking Additional information  □ Business trip □ Cruise ship trip □ Camping/hostels  □ 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 eg. your  spleen or thymus gland removed | | | | |  | |  | | |  | | |
| Recent chemotherapy/radiotherapy/organ transplant | | | | |  | |  | | |  | | |
| Anaemia | | | | |  | |  | | |  | | |
| Bleeding /clotting disorders (including history of DVT) | | | | |  | |  | | |  | | |
| Heart disease (eg. angina, high blood pressure) | | | | |  | |  | | |  | | |
| Diabetes | | | | |  | |  | | |  | | |
| Disability | | | | |  | |  | | |  | | |
| Epilepsy/seizures | | | | |  | |  | | |  | | |
| Gastrointestinal (stomach) complaints | | | | |  | |  | | |  | | |
| Liver and or kidney problems | | | | |  | |  | | |  | | |
| HIV/AIDS | | | | |  | |  | | |  | | |
| Immune system condition | | | | |  | |  | | |  | | |
|  | | | **YES** | | **NO** | | | **DETAILS** | | |
| 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 breast feeding? | | |  | |  | | |  | | |
| Are you planning pregnancy while away? | | |  | |  | | |  | | |
| Have you undergone FGM / been cut / circumcised | | |  | |  | | |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ARE YOU CURRENTLY TAKING ANY MEDICATION (INCL PRESCRIBED, PURCHASED OR A 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 | | |
| COVID-19 (dates, brand etc.) | | | | | | |
| **HAVE YOU TAKEN ANY MALARIA TABLETS IN THE PAST?** | | | | | | |
| **YES / NO DATE TAKEN IF APPLICABLE:** | | | | | | |
| **ADDITIONAL INFORMATION:** | | | | | |
|  | | | | | |