|  |  |
| --- | --- |
| Name: Click here to enter text. | Your country of birth:Click here to enter text. |
| Male [ ]  Female [ ]  Non-binary [ ]  | Date of Birth:Click here to enter a date. |
| Weight ( if Baby or child): Click here to enter text. | Date weight measured: Click here to enter a date. |
| Email:Click here to enter text. | Telephone Number: Click here to enter text. |
| GP: Click here to enter text. |
| PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW |
| Date of departure: Click here to enter a date. | Total length of Trip: Click here to enter text. |
| **COUNTRY TO BE VISITED** | **EXACT LOCATION OR REGION** | **LENGTH OF STAY** (days) | **MODE/S OF TRANSPORT** |
| 1. Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2. Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 3. Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 4.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Have you checked the [Fit for Travel](https://www.fitfortravel.nhs.uk/home.aspx) website?  | Y[ ]  | N[ ]  | Please detail recommendations from [Fit for Travel](https://www.fitfortravel.nhs.uk/home.aspx) |
|  |
| Have you checked your current vaccination history? (please detail in section below) | Y[ ]  | N[ ]  |
| Do you have travel health insurance for this trip? (covering pre-existing health conditions and planned activities if relevant.)  | Y[ ]  | N[ ]  |
| Do you plan to travel abroad again in the future? | Y[ ]  | N[ ]  |
| **DESTINATION DESCRIPTION – PLEASE CHOOSE ALL THAT APPLY** |
| Urban  |[ ]  Coastal |[ ]  Jungle |[ ]  High Altitude(>3000m) |[ ]
| Rural(Countryside) |[ ]  Safari |[ ]  Desert |[ ]  other |  |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP – PLEASE CHOOSE ALL THAT APPLY**  |
| Holiday |[ ]  Backpacking |[ ]  Business/Work |[ ]  Additional Information |
| Adventure/Gap Year |[ ]  Cruise ship trip |[ ]  Diving |[ ]  Click here to enter text. |
| Expatriate/Long Term |[ ]  Volunteer Work |[ ]  Climbing |[ ]  Click here to enter text. |
| Aide/Emergency Worker |[ ]  Pilgrimage |[ ]   |[ ]   |
| Visiting Friends/Family |[ ]  Medical Tourism |[ ]   |[ ]   |
| **ACCOMMODATION – PLEASE CHOOSE ALL THAT APPLY** |
| Hotel |[ ]  Hostel |[ ]  Camping |[ ]  Staying with friends/family |[ ]
| Jungle |[ ]  Desert |[ ]  Coastal  |[ ]  High Altitude(>3000m) |[ ]
| **PLEASE SUPPLY INFORMATION ON ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** |
| VACCINE | Date(s) of Vaccination | Dates not known |  | VACCINE | Date(s) of Vaccination | Dates not known |
| BCG | Click here to enter a date. |[ ]   | Cholera | Click here to enter a date. |[ ]
| COVID-19 | Click here to enter a date. |[ ]   | Diphtheria/Tetanus/ Polio | Click here to enter a date. |[ ]
| Hepatitis A | Click here to enter a date. |[ ]   | Hepatitis A/B | Click here to enter a date. |[ ]
| Hepatitis A/Typhoid | Click here to enter a date. |[ ]   | Hepatitis B | Click here to enter a date. |[ ]
| Japanese Encephalitis | Click here to enter a date. |[ ]   | Influenza | Click here to enter a date. |[ ]
| Meningitis ACWY | Click here to enter a date. |[ ]   | MMR | Click here to enter a date. |[ ]
| Rabies | Click here to enter a date. |[ ]   | Tick-borne encephalitis | Click here to enter a date. |[ ]
| Typhoid | Click here to enter a date. |[ ]   | Yellow Fever | Click here to enter a date. |[ ]
| Malaria Tablets | Click here to enter a date. |[ ]   | Currently taking Malaria medication | Click here to enter a date. |[ ]
| Other ( complete details section below) |
| **PLEASE SUPPLY DETAILS OF YOU PERSONAL MEDICAL HISTORY (please indicate with a X)** |
|  | Yes | No | Details |
| Are you fit and well today |[ ] [ ]  Click here to enter text. |
| Any Allergies including food, latex, medication |[ ] [ ]  Click here to enter text. |
| Have you, or anyone in your family, had a sever reaction to a vaccine or malaria medication before? |[ ] [ ]  Click here to enter text. |
| Have you ever had any surgery? e.g. open-heart surgery, spleen or thymus gland removal |[ ] [ ]  Click here to enter text. |
| Anaemia |[ ] [ ]  Click here to enter text. |
| Bleeding /clotting disorders (including history of DVT) |[ ] [ ]  Click here to enter text. |
| Heart disease (e.g. angina, high blood pressure) |[ ] [ ]  Click here to enter text. |
| Diabetes |[ ] [ ]  Click here to enter text. |
| Additional needs and/or disability |[ ] [ ]  Click here to enter text. |
| Epilepsy/seizures (or in a first degree relative?) |[ ] [ ]  Click here to enter text. |
| Gastrointestinal (stomach) complaints |[ ] [ ]  Click here to enter text. |
| Liver and or kidney problems |[ ] [ ]  Click here to enter text. |
| In the last 12 months, have you taken any medication, or had any treatment that could impair your immune system? e.g. chemotherapy/radiotherapy/organ transplant/ high dose steroids |[ ] [ ]  Click here to enter text. |
| Have you, or a first degree relative (parent, brother, sister or child) ever experienced mental health issues, even mild anxiety, or depression? |[ ] [ ]  Click here to enter text. |
| Neurological (nervous system) illness |[ ] [ ]  Click here to enter text. |
| Respiratory (lung) disease  |[ ] [ ]  Click here to enter text. |
| Rheumatology (joint) conditions |[ ] [ ]  Click here to enter text. |
| Spleen problems |[ ] [ ]  Click here to enter text. |
| Do you have, or had, a condition that could impair your immune system e.g. blood cancer, HIV/AIDS |[ ] [ ]  Click here to enter text. |
| Are you receiving regular treatment or follow up with your GP/ hospital specialist? |[ ] [ ]  Click here to enter text. |
| Do you have any disability or mobility problems? |[ ] [ ]  Click here to enter text. |
| Are you or your partner pregnant or planning a pregnancy? |[ ] [ ]  Click here to enter text. |
| Are you breast feeding (if applicable) |[ ] [ ]  Click here to enter text. |
| Have you or anyone in your family undergone FGM / been cut / circumcised |[ ] [ ]  Click here to enter text. |
| Any other conditions? |[ ] [ ]  Click here to enter text. |
|  |  |  |  |
| **Please provide details – name, dose/frequency of any medication you are currently taking/prescribed** (including prescribed, purchased or contraceptive pill?) |
| Click here to enter text.Click here to enter text.Click here to enter text.Click here to enter text.Click here to enter text. |
| Any additional information. – Click here to enter text.Click here to enter text.Click here to enter text.Click here to enter text. |