|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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. | | | | | | | | | | | | | | | | | | | | | | | | |