First Name(s) _____Last Name_____

Current Age_____ Date of Birth _____ Sex: Male ☐ Female ☐

Nationality _____ Country of Birth_____

Occupation_____ Company Name/Employer_____

Address_____

YOUR TRIP

Planned departure date/city_____

Planned return date/city_____

☐ Business ☐ Visiting family/friends ☐ Other_____

☐ Holiday ☐ Volunteer

Please list in order the cities/countries you plan to visit and how long you plan to spend in each (please note any airport stopovers in other countries while en route):

City/Country	**Length of Stay** (circle day or week)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)
	Day(s)/Week(s)

Planned & Possible Activities:

☐ Diving/Water Activities ☐ Hiking/Trekking ☐ High altitude ☐Volunteer work

☐ Farm/livestock work ☐ Camping ☐ Organised Tour ☐ Cycling

☐ Travel to rural/remote locations

☐ Medical/healthcare work

Accommodation arrangements: (tick all that apply)

☐ Hotels or Motels ☐ Backpackers or Hostels ☐ Rural accommodation ☐ Family or friends

☐ Campervan ☐ Camping ☐ Budget ☐ Private Home

YOUR HEALTH

Have you travelled to less developed countries before? ☐ Yes ☐ No

Have you ever had any health problems while you have been away/travelling? ☐ Yes ☐ No

If yes, please describe_____

Did you miss any of your childhood vaccinations? ☐ No ☐ Yes

Do you currently have a fever or infection? ☐ No ☐ Yes

Have you been in hospital, ill or injured in the last six weeks? ☐ No ☐ Yes

Are you currently undergoing or awaiting any medical investigations/specialist reviews or treatments?

☐ No ☐ Yes

Have you had a blood transfusion or immunoglobulins in the last year?

☐ No ☐ Yes

Have you ever fainted after a vaccination/injection or after giving blood?

☐ No ☐ Yes

Do you have any specific health issues or concerns in relation to your trip?

☐ No ☐ Yes

Past & Current Health History (Tick those that apply and where possible specify, please include any surgical procedures)

Do you have any of the following:

Heart conditions (e.g Heart disease/heart attack, angina stents, atrial fibrillation,irregular heart beat)

☐ Yes ☐No
If yes, please describe_____

Lung/Respiratory conditions (e.g: asthma, COPD, emphysema, chest problems, bronchiectasis, and bronchitis)

☐Yes ☐No
If yes, please describe_____

Skin Conditions (e.g. skin cancers, eczema, dermatitis)

☐ Yes ☐No
If yes, please describe_____

Depression/Mental Health conditions (e.g. anxiety, depression, panic attacks, fear of flying, schizophrenia, Alzheimer disease)

☐Yes ☐No
If yes, please describe_____

Gastrointestinal conditions (e.g. reflux, stomach ulcers, bowel or gastric cancers, gallstones, pancreas problems)

☐ Yes ☐ No
If yes, please describe_____

Musculoskeletal conditions (e.g. bone problems, back problems, joint replacement, arthritis, require walking aids/assistance)

☐Yes ☐No
If yes, please describe_____

Neurological conditions/Seizure disorder (e.g. stroke, epilepsy, Parkinson Disease)

☐ Yes ☐No
If yes, please describe_____

Do you have any of the following:

☐ High blood pressure ☐Diabetes ☐ Previous blood clots ☐ Migraines

☐ Eye Conditions ☐ HIV/AIDs ☐ Immune disorder

☐ Other _____
_____
_____

Have you had your spleen removed? ☐Yes ☐ No

Do you have or have you previously had a thymus disorder? ☐Yes ☐No

If you are female, are you pregnant, planning to get pregnant or currently breastfeeding?

☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

My current medications are (please include regular and occasional medications and include any herbal/supplements, recreational drugs or over the counter medications:

_____
_____
_____
_____
_____

Have you previously taken any anti-malaria medications? (Please specify if possible)

☐ No ☐Yes _____

Did you encounter any side effects or problems with these?

☐No ☐Yes

If Yes, please describe:_____

Allergies

Are you allergic to anything (These include to food, skin, antibiotics or other medications e.g sulfur-based medications penicillin, tetracyclines, neomycin, mercury/thiomersal, gelatin, iodine, eggs, latex, sticking plasters/band aids, insect bites or stings):

_____
_____
_____

Previous vaccinations (please include date last given if able):

_____
_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire.