|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PERSONAL DETAILS | | | | |
| Name | | | Date of Birth | |
| Contact tel number | | Email address | | |
| TRIP DETAILS | | |  | |
| Date of Departure | | | Length of stay overall | |
| Date of Return | | |
| DESTINATION (S) | | | | |
| Countries to be visited | Areas staying within Country | | | Length of stay |
| 1. |  | | |  |
| 2. |  | | |  |
| 3. |  | | |  |
| 4. |  | | |  |
| **Do you plan to travel abroad again in the future?**  **YES / NO** ( circle) | | | | |
| DECRIBE YOUR TRIP ( packaged tour , backpacking, business, cruise, etc) | | | | |
|  | | | | |
| PERSONAL MEDICAL HISTORY | | | | |
| Any Recent or past medical history – ( heart problems, lung conditions, diabetes , epilepsy, mental illness including anxiety or depression etc) | | | | |
| Any problems with vaccinations in the past ? | | Allergies? | | |
| **Women only** : are you pregnant, planning a pregnancy or currently breastfeeding ? | | | | |
| PREVIOUS VACCINATION HISTORY | | | | |
| **Are you up to date with any childhood vaccinations? YES/NO** (circle) | | | | |
| **Following discussion during my travel consultation and based on the information I have given I consent to having vaccines as recommended by my health professional. I have received the information on the risks and benefits of the vaccines recommended**  Patient Signature | | | | |