Medical Tourism Participant Health Declaration Form

Personal Information

Full Name

Gender

Date of Birth

Passport Number

Nationality

Contact Number

Email Address

Travel Information

Arrival Date

Departure Date

Destination Hospital/Clinic

Permanence Address

Medical History

Have you had any of the following conditions? (Select all that apply)

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Asthma
- [ ] None

Please list any other significant illnesses, allergies, or surgeries

Are you currently taking any medication?

If yes, please list the medications

COVID-19 & Infectious Disease Declaration

Have you experienced any symptoms such as fever, cough, or difficulty breathing in the last 14 days?

Have you been in contact with a confirmed case of COVID-19 or any contagious disease in past 14 days?

Declaration & Consent

I hereby declare that the information provided above is true and correct to the best of my knowledge.

I agree

Date

Signature