Pre-Travel Health Assessment Form

Full Name

Date of Birth

Gender

Contact Number

Email Address

Intended Travel Destination(s)

Departure Date

Return Date

Do you have any chronic medical conditions?

If yes, please specify

Are you currently taking any medication?

If yes, list medication(s)

Do you have any drug allergies?

If yes, please specify

Have you received all recommended routine vaccinations?

If no, please specify vaccines not received

Other relevant information or concerns