Travel Health Medical History Form

Personal Information

Full Name

Date of Birth

Passport Number

Country of Residence

Emergency Contact

Phone Number

Travel Details

Destination(s)

Departure Date

Return Date

Purpose of Travel

Accommodation Details

Medical History

Do you have any chronic illnesses?

Yes

No

If yes, please specify

Do you have any allergies?

Yes

No

If yes, please specify

Are you currently taking any medications?

Yes

No

If yes, list medications

Immunization

Have you received the following vaccinations?

Yellow Fever

Typhoid

Hepatitis A

Hepatitis B

Tetanus

Rabies

Other

If other, please specify

Additional Information

Please provide any additional information relevant to your travel health