## INTAKE-FORM TRAVELLER

*Please fully fill out this form. Only tick items when applicable to you.*

Name: …… Date of birth:……/……/……..
Country of birth/childhood: …… In the Netherlands since: ……/……/…….
BSN:…….. Telephone:…….
Weight:……kg Date of departure: ……./……./……

| Country of destination: | Area/place: | Duration: | Country of destination: | Area/place: | Duration: |
|---|---|---|---|---|---|
| 1. | | | 3. | | |
| 2. | | | 4. | | |

**Travel purpose:** ☐holiday ☐visiting family/friends ☐migration ☐occupation/education:……

**Travelling company:** ☐on my own ☐partner/family ☐other:…….

**Accommodation:** ☐hotel ☐apartment ☐camping ☐ship ☐family/friends ☐with locals ☐hostel

**Activities:** ☐travel to high altitude (>2500 m) ☐animal contact ☐medical practice ☐……

---

Have you been vaccinated as a child? ☐no ☐yes ☐partially ☐unknown
Have you been vaccinated before? ☐no ☐yes ☐in military service ☐for travel ☐for work
Have you ever had side effects due to vaccination? ☐no ☐yes vaccine + date:……..
Have you ever had side effects from malaria tablets? ☐no ☐yes
Are you allergic to any substance? ☐no ☐yes ☐chicken egg ☐medicines:……
Have you ever fainted after vaccination? ☐no ☐yes

---

Are you currently consulting a doctor? ☐no ☐yes reason:……..
doctor:……
Do or did you have any of the following diseases? ☐no ☐yes ☐stomach/ bowel/ liver disease ☐kidney disease
☐diabetes ☐cardiovascular disease ☐epilepsy
☐psoriasis ☐blood clotting disease ☐cancer
☐immune disorder ☐hiv/AIDS ☐spleen disorder
☐thymus disorder ☐dengue (breakbone fever)
☐other……
Have you had hepatitis A or B (jaundice)? ☐no ☐yes ☐A ☐B ; ☐jaundice ☐antibody positive
Born 1965 or after: Have you had measles? ☐no ☐yes ☐unknown
Born 1965 or after: Have you been vaccinated against measles? ☐no ☐yes ☐unknown
Do you have or have had a psychiatric problem? ☐no ☐yes ☐depression ☐anxiety disorder
☐psychosis ☐other:…….
Do you use any medication? ☐no ☐yes ☐antacids ☐anticoagulants ☐immunosuppressants
(Including medication not on doctor's prescription) ☐antibiotic ☐hiv-therapy ☐oral contraceptive
☐other:……..
Have you received chemo- or radiation therapy? ☐no ☐yes If so, when? ……
Have you ever had surgery? ☐no ☐yes ☐stomach ☐bowel ☐spleen ☐other:……
Have you got a vascular- or heart valve implant? ☐no ☐yes ☐vascular implant ☐heart valve implant

**For women:**

Are you pregnant? ☐no ☐yes ☐don't know If so, how long?……..
Are you planning to get pregnant in the near future? ☐no ☐yes If so, when was your last menstruation?:……..
Are you breastfeeding? ☐no ☐yes ……

**For children <1 year:** Did the mother use biologicals during the pregnancy? ☐no ☐yes

Have you ever had health problems while traveling? ☐no ☐yes ……
Are there any other issues you want to discuss? ☐no ☐yes ……

*I declare to have filled out this form truthfully.*
Date: ……/……/……. Signature:…… Travel health advisor's initial:.....