Travellers Advice & Vaccination Centre

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

Surname _____ Initials _____ m / f Date of birth _____

Country of birth/ childhood _____ In the Netherlands since _____

Address _____ Postal code _____ City _____

E-mail _____ Telephone _____ BSN _____

Profession _____ Body weight _____ kg Date of departure _____

Country of destination _____ Area/place _____ Duration _____

1. _____ 2. _____ 3. _____

Travel purpose ☐ holiday ☐ visiting family/friends ☐ migration ☐ occupation/education _____

Travelling party ☐ on my own ☐ partner/family ☐ other _____

Accommodation ☐ hotel ☐ apartment ☐ camping ☐ ship ☐ family/friends ☐ with locals

Activities ☐ travel to high altitude (>2500 m) ☐ animal contact ☐ medical practice _____

Have you received vaccinations before?	☐ no	☐ yes	☐ in childhood ☐ unknown	☐ in military service	☐ for travel
Are you currently consulting a doctor?	☐ no	☐ yes	reason doctor		
Do you use any medication or/and oral contraceptive? *Including medication not on doctor's prescription*	☐ no	☐ yes	☐ anticoagulants ☐ other	☐ antacid	☐ HIV therapy
Are you allergic to any substance?	☐ no	☐ yes	☐ chickenegg	☐ antibiotics	
Do or did you have any of the following diseases?	☐ no	☐ yes	☐ stomach/bowel disease ☐ kidney disease ☐ blood clotting disease ☐ spleen disorder ☐ cardiovascular disease ☐ rheumatism	☐ liver disease ☐ psoriasis ☐ immune disorder ☐ thymus disorder ☐ other	☐ diabetes ☐ epilepsy ☐ hiv/aids ☐ cancer
Have you ever had hepatitis A or B (jaundice)?	☐ no	☐ yes	☐ A ☐ antibody positive	☐ B	☐ jaundice
Have you had a psychiatric problem?	☐ no	☐ yes	☐ depression ☐ other	☐ anxiety disorder	☐ psychosis
Have you received chemo- or radiation therapy?	☐ no	☐ yes	year		
Have you ever had surgery?	☐ no	☐ yes	☐ spleen ☐ other	☐ stomach	☐ bowel
Have you got a vascular or heart valve prosthesis?	☐ no	☐ yes	☐ vascular prosthesis	☐ heart valve prosthesis	
Are you pregnant?	☐ no	☐ yes	☐ possible	duration of pregnancy	
Are you planning to get pregnant in the near future?	☐ no	☐ yes	date last period		
Are you breastfeeding?	☐ no	☐ yes			
Have you ever had health problems from travel?	☐ no	☐ yes			
Have you ever had side effects due to vaccination?	☐ no	☐ yes	vaccine + date		
Have you ever had side effects from malaria tablets?	☐ no	☐ yes			
Did you ever faint after a vaccination?	☐ 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 _____

(Client's signature in case a particular advice is refused) _____