

INTAKE-FORM TRAVELLER

LCR

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

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 in military service for travel
unknown
 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 chickenegg medicines:.....

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 kidneydisease
diabetes cardiovascular disease epilepsy
psoriasis blood clotting disease cancer
immunodisorder hiv/AIDS spleen disorder
thymusdisorder other:.....
 Have you had hepatitis A or B (jaundice)? no yes A B ; jaundice antibody positive
 Have you had a psychiatric problem? no yes depression anxiety disorder psychosis
other:.....
 Do you use any medication or oral contraceptive? no yes antacid anticoagulans immunosuppressant
 (Including medication not on doctor's prescription) antibiotic hiv-therapy oral contraceptive
other:.....
 Have you received chemo- or radiation therapy? no yes
 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
 Are you pregnant? no yes don't know How long?.....
 Are you planning to get pregnant in the near future? no yes Last menstruation:.....
 Are you breastfeeding? no yes
 Have you ever had health problems from travel? 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:)