SASTM
Guiding the Profession
Protecting the Public

TRAVELLER PATIENT INFORMATION FORM

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PERSONAL INFORMATION			
Title / Surname		Postal Address	
Given Names			
ID Number			
Occupation			
Doctor's Name & Tel		Telephone (W)	
		(H)	
Email Address		(Cell)	

TRAVEL DETAILS

Countries to be visited	Departure Date	Length of Stay	Type of area to be visited		Reason for Travel	
			Urban	Rural	Business	Leisure

Type of Accommodation	Hotel	Self Catering	Camping	Friends / Relatives	Construction Camp	Other

Activities	Will you be climbing, diving or piloting an aircraft?	Y	N	Do you work at heights or operate machinery?	Y	N

MEDICAL HISTORY: If yes please provide complete details

Family History	Y	N		Y	N
Epilepsy or any other neurological problem			Psoriasis		
Have you ever had / do you have now			Porphyria		
Epilepsy or fits of any kind			Hepatitis / Yellow Jaundice		
Asthma			Surgery		
Blood disorder			Removal of spleen		
Arthritis			Have you		
Psychiatric disorder, depression, anxiety etc			Lost more than 5kg in weight in the past 12 months		
Cancer or Leukemia			Had a blood test for HIV (no need to provide results)		
Chronic disorder i.e. heart disorder			Are you pregnant		
High blood pressure			Medication: Are you		
Indigestion			On any medical treatment		
Kidney problems			Taking cortisone		
Migraine					

Details

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: If yes provide complete details

	Y	N		Y	N	Details
Eggs / Chicken			Antibiotics			
Anti malarial drug			Other allergies			
Sulphonamides						

IMMUNIZATIONS

When were you last immunized?	Date		Date		Y	N
Polio		Rabies		Have you had a reaction to immunizations?		
Tetanus		Japanese B *(Encephalitis)*		If yes, state to which immunization and the nature of the		
Cholera		Hepatitis A		reaction		
Diphtheria		Hepatitis B				
Typhoid		Meningitis				
Yellow Fever		Other				

SIGNATURE	**DATE**