

## TRAVELANAMNESIS

Please complete one form per person  
 Please complete this form as accurately as possible in block letters  
 If possible bring your vaccination documents and your itinerary

Surname:	Sex: M or F	Initials:	Date of birth:
Country of birth:		Date of immigration (if not born in The Netherlands):	
Email:		Mobile Number:	
Street and house number:		Zip code and place:	
Telephone number:		Profession:	

<b>Reason for journey:</b>	<input type="checkbox"/> Holiday <input type="checkbox"/> Residence	<input type="checkbox"/> Job <input type="checkbox"/> Visiting family or friends	<input type="checkbox"/> Otherwise:
<b>Accommodation:</b>	<input type="checkbox"/> Hotel or pension <input type="checkbox"/> Apartment <input type="checkbox"/> Family or friends	<input type="checkbox"/> Camping or tent <input type="checkbox"/> Guesthouse, lodge or hut <input type="checkbox"/> Local population	<input type="checkbox"/> Otherwise:
<b>Risky activities:</b>	<input type="checkbox"/> Residence >2500m altitude <input type="checkbox"/> Association with animals <input type="checkbox"/> Medical procedures	<input type="checkbox"/> Sex, tattoo or piercing <input type="checkbox"/> (water-) Sport	<input type="checkbox"/> Otherwise:
<b>Traveling party:</b>	<input type="checkbox"/> Group <input type="checkbox"/> Partner or family	<input type="checkbox"/> Friends <input type="checkbox"/> None (individual trip)	<input type="checkbox"/> Otherwise:

Medical data	Yes	No	Explanation
Are you under medical attendance?			Reason: Did you inform your doctor about your journey?
Do you suffer from a chronical illness?			<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart-vascular disease <input type="checkbox"/> Stomach-intestinal disease <input type="checkbox"/> Coagulation disorder <input type="checkbox"/> Skin disease <input type="checkbox"/> Otherwise: <input type="checkbox"/> Epilepsy <input type="checkbox"/> Kidney disease <input type="checkbox"/> HIV or AIDS <input type="checkbox"/> Liver disease
Do you use any medicine prescribed by a doctor (including contraceptive pills)? Do you use any over the counter medicine?			Which:
Did you ever suffer, now or in the past, from a depressive disorder, anxiety disorder or another psychic disease or problem?			<input type="checkbox"/> Depression <input type="checkbox"/> Addiction <input type="checkbox"/> Otherwise: <input type="checkbox"/> Psychosis <input type="checkbox"/> Anxiety disorder
Are you known with any allergy?			<input type="checkbox"/> Medicine <input type="checkbox"/> Chicken eggs or white of chicken egg <input type="checkbox"/> Otherwise: <input type="checkbox"/> Bee or wasp poison
Is your spleen removed or does your spleen not function optimal?			Reason:
Do you have a pacemaker or vascular prosthesis?			<input type="checkbox"/> Pacemaker <input type="checkbox"/> Artificial heart valve <input type="checkbox"/> Otherwise: <input type="checkbox"/> Stent
Did you have surgery?			When and why:
Are you under radiation treatment, do you receive chemotherapy or did you ever undergo one of these treatments?			Date and reason:
Are you currently pregnant or plan to get pregnant in the near future?			Number of weeks pregnancy:
Do you breast feed?			

