tmb TRAVEL HEALTH CLINICS

PATIENT INFORMATION FORM

PLEASE USE BLOCK CAPITALS

PATIENT REFERENCE NUMBER

Surname: First Name: Age: Date of Birth: (D/M/Y)

Address:

Contact Number: Email:

Country of Birth: Number Travelling in Group: Occupation:

Accommodation: Hotel / Hostel / Camping / Cruise

Reason for Trip: Business / Holiday / Assignment / Trekking / Visiting Friends

Proposed Countries (include stopovers):

Date of Departure: Duration: (weeks)

Past / Current Medical Problems: (please list)

Are you taking ANY medication? (please list)

Have you had ANY travel vaccines over the past 10 years? Yes / No

Are you pregnant? No / Yes / Unsure Planned

If applicable, date of last menstrual period: (D/M/Y)

Billed to Company: Yes P.O. Number

Who is your health insurance provider?

Where did you hear about us?

If Business: Company Name:

I hereby confirm that the information supplied is correct to the best of my knowledge and that I consent to treatment / vaccines following discussion.

Signed: Date:

If you DO want access to MyTMB - your online TMB patient record, please tick this box.

If you DO want to receive information updates and special offers from TMB please tick this box.

PLEASE CIRCLE THE FOLLOWING

Diabetes – Insulin / Medication	Yes	No
Epilepsy	Yes	No
Neurological Problems	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Contraceptive Pill / Implant	Yes	No
Heart Problems / Blood Pressure	Yes	No
Anxiety / Panic Attacks	Yes	No
Varicose Veins / Venous Thrombosis	Yes	No
On Steroids	Yes	No
Suppressed Immune System	Yes	No
(Very) Sensitive to Sunlight	Yes	No
(Very) Sensitive to Insect Bites	Yes	No
History of Jaundice at Birth	Yes	No
History of Infectious Jaundice	Yes	No
Allergy to Eggs	Yes	No
ANY KNOWN ALLERGIES (please list)	Yes	No
Prone to fainting?	Yes	No
Left or Right handed?	L	R