Tan Tock Seng Hospital
Travellers' Health & Vaccination Clinic

General Traveller: Please Complete Page 1 - 2

PERSONAL DATA:

Have you been to this clinic before? Yes / No **Year of last visit:** _____

Name: _____

Address: _____ ☐ No change in address (for those with visits within 3 yrs)

Address (line 2): _____

NRIC/Passport No: _____ **Nationality:** _____

Age: _____ **Gender: M / F** **Date of birth (dd/mm/yr):** _____

Race: _____ **Country of birth:** _____

Profession: _____ **Marital status:** _____

Contact No: (Mobile) _____ **(Residence)** _____ **(Work)** _____

TRAVEL ITINERARY:

Date of Departure: _____ **Date of Return:** _____

Destination: _____ **Dates / Duration of Stay:** _____

_____ _____

_____ _____

_____ _____

Are you travelling: **With family / friends / colleagues / tour group / alone**
(circle all that apply)

Are you travelling: **For business / holiday / educational trip / overseas studies /**
(circle all that apply) **volunteer work / mission or relief work / other** _____

Activities planned: **Mountaineering / trekking / scuba diving / river rafting /**
(circle all that apply) **Patient care / contact with animals / construction**

Main Reasons for clinic visit:
(circle all that apply)

A. Vaccines
B. Malaria prophylaxis & advice
C. Altitude illness medication & advice
D. Forms need to be completed
E. Longterm residence abroad ☐ MFA ☐ Mindef
F. Employer or program requirement
G. Other questions: _____

THV-VAC-01-03

PAST MEDICAL HISTORY: (please tick all that apply)

☐ Hypertension	☐ Asthma	☐ Cancer
☐ Diabetes	☐ Tuberculosis	☐ Autoimmune disease
☐ Heart disease	☐ Kidney disease	☐ Skin illness
☐ Stroke	☐ Liver disease	☐ Hayfever
☐ Cardiac arrythmia	☐ Seizure disorder	☐ Psychiatric illness

☐ Previous Surgery: _____

☐ Other Issues: _____

In the past 6 months, have you had any of the following: (circle all that apply)
Steroids / chemotherapy / radiation / immunosuppressive meds _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES:

Drug allergy:	Yes / No	If yes, specify:
Egg protein allergy:	Yes / No	If yes, specify:
Food allergy:	Yes / No	If yes, specify:
Bee sting allergy:	Yes / No	If yes, specify:
Vaccine allergy:	Yes / No	If yes, specify:
Anti-malarial reaction:	Yes / No	If yes, specify:

FEMALE TRAVELERS:

Last menstrual period: _____
Pregnant: Yes / No
Breastfeeding: Yes / No
Oral contraceptives: Yes / No

☐ Not applicable - male
☐ Post-menopausal
☐ Child

PREVIOUS VACCINES & DATES:

☐ Diphtheria/tetanus _____

☐ Cholera _____

☐ Hepatitis A _____
☐ Immune

☐ Hepatitis B _____
☐ Immune

☐ Twinrix (Hep A/B) _____

☐ Influenza _____

☐ Japanese encephalitis _____

☐ Measles/mumps/rubella _____

☐ Meningococcal
☐ A/C _____
☐ A/C/Y/W135 _____

☐ Pneumococcal _____

☐ Polio _____

☐ Rabies _____

☐ Typhoid ☐ Oral _____
☐ Injected _____

☐ Varicella _____
☐ Immune (history of chickenpox)

☐ Yellow fever _____