



TRAVELER HEALTH QUESTIONNAIRE

Travelers Details

Full names*	Sex
Age	
Country of original departure	
Passport number	
Occupation*	
Flight/Vessel number/name*	
Seat number*	
Countries visited in the last 30 days*	
Reasons for visiting Zambia	
Duration of stay	
Contact Number in Zambia:	Alternative Contact Number:

E-mail:

Address in Zambia*

Health Information

Do you have any of the following symptoms? (please tick all that apply)

- Fever
- Abdominal pain
- Rash
- Vomiting
- Headache
- Muscle pain
- Jaundice (yellowing of eyes and skin)
- Diarrhea
- Bruising or bleeding
- Cough
- Sore throat
- Breathing difficulties
- Shortness of breath

Temperature reading

The traveler hereby certifies that the information he/she has provided is true and that he/she subjects himself/herself to further assessment at a designated health facility (if he/she has any signs and symptoms listed above). If the traveler does not have the symptoms listed above, they must be followed up either by telephone/mobile phone or physically at a place of destination in Zambia for a period of 14 - 21 days. In an event that you develop any of the above symptoms within 14 - 21 days, please contact the nearest health facility.

Signature of traveler: _____

Date: _____

FOR OFFICE USE ONLY

Port Health Official details

Name:	Province:	Point of entry:
Telephone of Institution:	Mobile Number:	E-mail:
Health facility details if traveler referred		
Name of Health Facility:	Examining clinician:	Tel no. of examining clinician:

GENERAL COMMENTS:

