



Ministry of health  
REPUBLIC OF ZAMBIA

TRAVELER HEALTH QUESTIONNAIRE

| Traveler's details                     |                             | Health Information  |
|--|-----------------------------|---|
| Full names*                            |                             | Do you have any of the following symptoms? (please tick all that apply)<br><input type="checkbox"/> Fever <input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Abdominal pain<br><input type="checkbox"/> Rash <input type="checkbox"/> Bruising or bleeding<br><input type="checkbox"/> Vomiting <input type="checkbox"/> Cough<br><input type="checkbox"/> Headache <input type="checkbox"/> Sore throat<br><input type="checkbox"/> Muscle pain <input type="checkbox"/> Breathing difficulties<br><input type="checkbox"/> Shortness of breath<br><br><input type="checkbox"/> Jaundice (yellowing of eyes and skin)<br><br>Temperature reading..... |
| Age                                    | Sex                         |   |
| 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*          |   |

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: |
| <b>GENERAL COMMENTS:</b>                     |                      |                                 |



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| TRAVELER HEALTH QUESTIONNAIRE   |  |                                |                    |             |  |           |                 |                               |                |                 |  |             |  |                            |                     |                                |                          |  |  |                             |  |                  |  |                           |                             |         |                    |
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