



香港醫學抗衰老診所
Hong Kong Anti Aging Clinic

Itinerary (please attach extra sheet if needed)

Destination (city, country)	Date	Nature of travel (✓ and circle as appropriate)		
		TRIP PURPOSE:	ACCOMMDATION	TRIP ACTIVITIES:
		<input type="checkbox"/> Business	<input type="checkbox"/> Hotel/Hostel	<input type="checkbox"/> Air travel
		<input type="checkbox"/> Study	<input type="checkbox"/> Private home	<input type="checkbox"/> Public transportation
		<input type="checkbox"/> Visit friends or relatives	<input type="checkbox"/> Camping	<input type="checkbox"/> Biking
		<input type="checkbox"/> Visit tourist area	<input type="checkbox"/> Cruise ship	<input type="checkbox"/> Water sport
		<input type="checkbox"/> Outdoor activities	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Climbing or Hiking
Return date		<input type="checkbox"/> Volunteer/humanity works		<input type="checkbox"/> Visiting Schools/hospitals/slum
Duration (Days)		<input type="checkbox"/> Other: _____		<input type="checkbox"/> Health care work
				<input type="checkbox"/> Contact with animals
				<input type="checkbox"/> Other: _____

Health Status :

(Please circle 'Yes' or 'No')

1. Do you have history of the followings:

Chronic illness, e.g. heart, kidney or liver disease ?

Yes / No

Epilepsy?

Yes / No

Mood disorder or psychiatric illness?

Yes / No

Psoriasis?

Yes / No

G6PD deficiency?

Yes / No

other disease (state if any: _____)

Yes / No

2. Are you pregnant or planning to be pregnant?

Yes / No

3. Are you breast feeding?

Yes / No

4. Do you have any chronic illness that needs regular follow up?

Yes / No (State if any: _____)

5. Are you taking any regular medication?

Yes / No (State if any: _____)

6. Are you allergy to:

Medicine? (state if any: _____)

Yes / No

Egg or chicken?

Yes / No

Others? (state if any: _____)

Yes / No

Do you have any specific health concern about this trip?

Name

Sex

