

# Health Passport



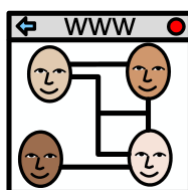
Name:



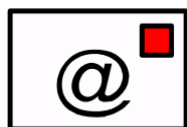
Date of Birth:



Phone:



Social Media:



Email:



Other Contacts:



Travelled with:





# Symptoms

stomach  
ache



nausea



diarrhoea



constipation



urine pain



bleeding



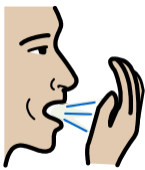
foot ulcer



numb foot



cough



cold



sore throat



temperature



headache



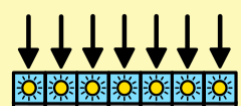
toothache



earache



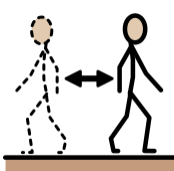
every day



depressed



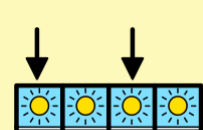
restless



can't sleep



some days



1

2

3

4

5

6

7

8

9

10



## My Medical History

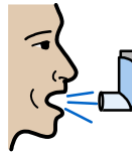
heart  
problem



diabetes



asthma



breath  
problems



kidney  
problem



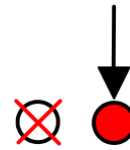
stroke



epilepsy



other



## My Medication

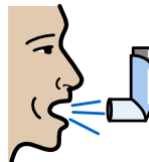
tablets



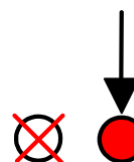
insulin

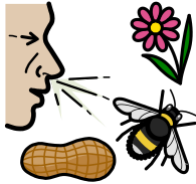


inhaler



other





## My Allergies

medicine



insect sting



pollen



gluten



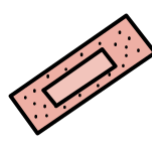
dairy food



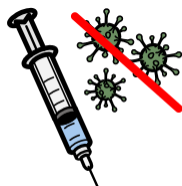
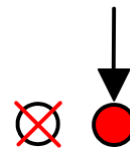
fur



plaster



other

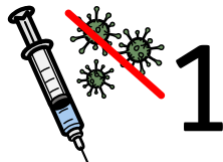


## Covid Vaccination

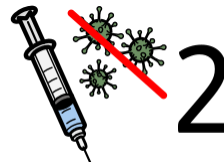
No Vaccine



1st dose



2nd Dose



3rd Dose

