Travel Questionnaire

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| **Personal Details** | | | |
| Name: |  | Sex: | Female  Male |
| Date of Birth: |  | Postcode: |  |
| Daytime Tel: |  | | |
| Email: |  | | |
| **Trip Dates** | | | |
| Departure: |  | Duration: |  |
| **Itinerary** | | | |
| Country | | Duration | Availability of Medical Help ***(i)*** |
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| **Trip Description - please tick all appropriate boxes:** | | | |
| Purpose of Trip: | Business Pleasure Other | | |
| Type of Trip: | Package Self-Organised Backpacking | | |
| Camping Cruise Ship Trekking | | |
| Accommodation: | Hotel Friends/Family Other | | |
| Travelling: | Alone With Friend/Family In a Group | | |
| Location Type: | Urban Rural Altitude***(i)*** | | |
| Activity Type: | Safari Adventure Other | | |
| **Personal Medical History** | | | |
| List all chronic medical conditions that you have (eg. diabetes, heart or lung conditions) | | | |
| List all allergies that you have (eg. eggs, nuts, antibiotics) | | | |
| If you have had a serious reaction to a vaccine in the past, which vaccine was it? | | | |
| List all of your current medications (including oral contraception) | | | |
| Have you recently suffered from any infection (e.g heavy cold, flu or high temperature)? | | | Yes |
| Does having an injection cause you to feel faint? | | | Yes |
| Do you or any close family members have epilepsy? | | | Yes |
| Do you have any history of mental illness including depression or anxiety? | | | Yes |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | | | Yes |
| Have you taken out travel insurance? | | | Yes |
| If you have a medical condition, have you told your insurance company about it? | | | Yes |
| Are you pregnant, planning pregnancy or breast feeding? | | | Yes |
| Write below any further information that might be relevant | | | |
| **Vaccination History** | | | |
| Have you ever had any of the following vaccinations / tablets and if so, when? | | | |
| Tetanus | Yes | Polio | Yes |
| Diphtheria | Yes | Typhoid | Yes |
| Hepatitis A | Yes | Hepatitis B | Yes |
| Meningitis | Yes | Yellow Fever | Yes |
| Influenza | Yes | Rabies | Yes |
| Jap B Enceph | Yes | Tick Borne | Yes |
| Malaria Tablets | Yes | Other |  |



Enter a date in the format  
dd/mm/yyyy 