Travel Questionnaire

|  |
| --- |
| **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)***  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **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 