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		

Send

Enter a date in the format dd/mm/yyyy