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		