Travel Questionnaire

Personal Details:

Name: _____

Date of Birth: ____/_____/_____

Address:

_____

_____

_____

Contact Number: _____

Email: _____

Gender (please tick):

☐ Woman (Including Trans Woman)

☐ Man (Including Trans Man)

☐ Non-binary

☐ Other _____

Trip Dates:

Departure: ____/____/_____

Duration: _____

Itinerary:

Please fill out the following table:

Country	Duration	Availability of Medical Help

Purpose of Trip (please tick):

☐ Business

☐ Pleasure

☐ Other _____

Type of Trip (please tick):

☐ Package ☐ Self-Organised ☐ Backpacking

☐ Camping ☐ Cruise Ship ☐ Trekking

☐ Other _____

Accommodation (please tick):

☐ Hotel

☐ Friends/Family

☐ Other _____

Travelling (please tick):

☐ Alone

☐ With friends/family

☐ In a group

☐ Other _____

Location Type (please tick):

☐ Urban

☐ Rural

☐ Altitude

☐ Other _____

Activity type (please tick):

☐ Safari

☐ Adventure

☐ Other _____

Personal History

Please list any chronic diseases that you have (e.g. diabetes, heart or lung conditions):

_____

_____

_____

Please list any allergies that you have:

_____

_____

_____

If you have had a serious rection to a vaccine in the past, which vaccine was it?

_____

_____

Please list all your current medications below:

_____

_____

_____

Have you recently suffered from any infection (e.g heavy cold, flu or high temperature)?

☐ Yes ☐ No

Does having an injection cause you to feel faint?

☐ Yes ☐ No

Do you or any close family members have epilepsy?

☐ Yes ☐ No

Do you have any history of mental illness including depression or anxiety?

☐ Yes ☐ No

Have you recently undergone radiotherapy, chemotherapy, or steroid treatment?

☐ Yes ☐ No

Have you taken out travel insurance?

☐ Yes ☐ No

If you have a medical condition, have you told your insurance company about it?

☐ Yes ☐ No

Are you pregnant, planning pregnancy or breast feeding?

☐ Yes ☐ No

Please write below any further information you think might be relevant:

_____

_____

_____

_____

_____

_____

Vaccination History

Have you had any of the following vaccines/tablets? If so, when?

Vaccination/Tablet	Yes/No/Unsure	Date received
Tetanus		
Diphtheria		
Hepatitis A		
Meningitis		
Influenza		
Jap B Enceph		
Malaria Tablets		