

Travel Questionnaire

Personal Details:

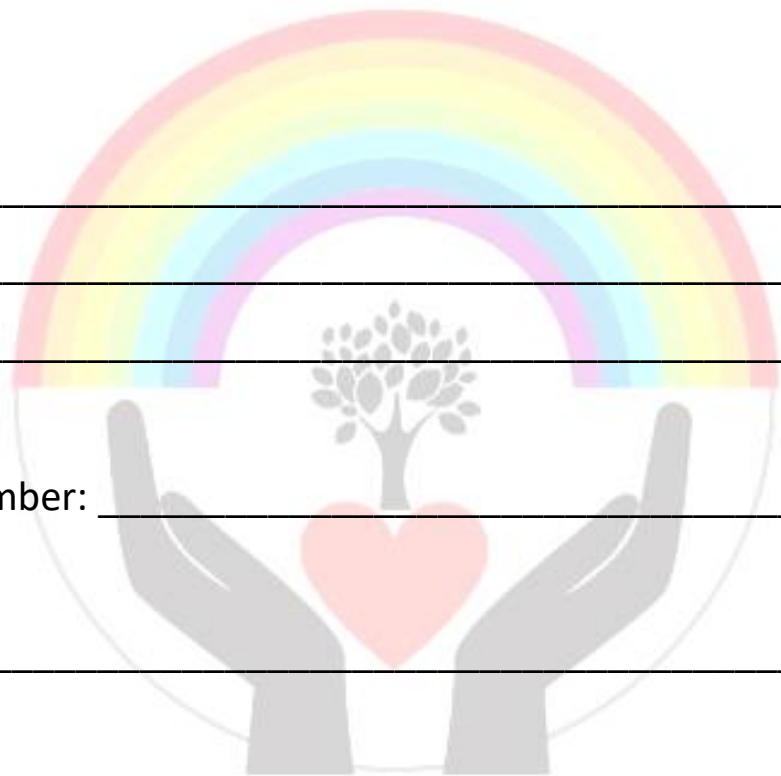
Name: _____

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):

- | | | |
|--------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Package | <input type="checkbox"/> Self-Organised | <input type="checkbox"/> Backpacking |
| <input type="checkbox"/> Camping | <input type="checkbox"/> Cruise Ship | <input type="checkbox"/> Trekking |
| <input type="checkbox"/> Other _____ | | |

Accommodation (please tick):

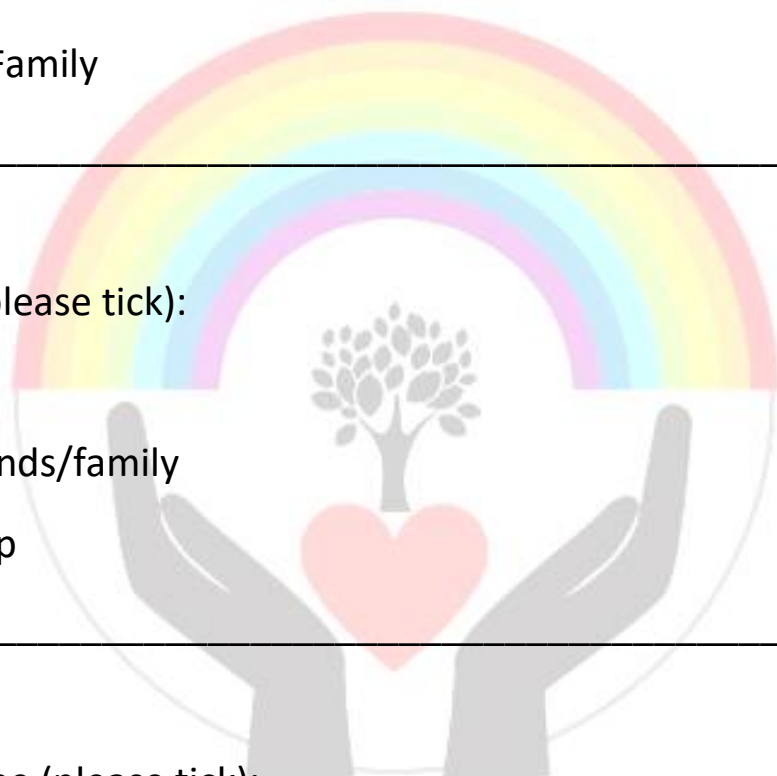
- | |
|---|
| <input type="checkbox"/> Hotel |
| <input type="checkbox"/> Friends/Family |
| <input type="checkbox"/> Other _____ |

Travelling (please tick):

- | |
|--|
| <input type="checkbox"/> Alone |
| <input type="checkbox"/> With friends/family |
| <input type="checkbox"/> In a group |
| <input type="checkbox"/> Other _____ |

Location Type (please tick):

- | |
|--------------------------------------|
| <input type="checkbox"/> Urban |
| <input type="checkbox"/> Rural |
| <input type="checkbox"/> Altitude |
| <input type="checkbox"/> Other _____ |



KUMAR FAMILY
PRACTICE

Activity type (please tick):

☐ Safari

☐ Adventure

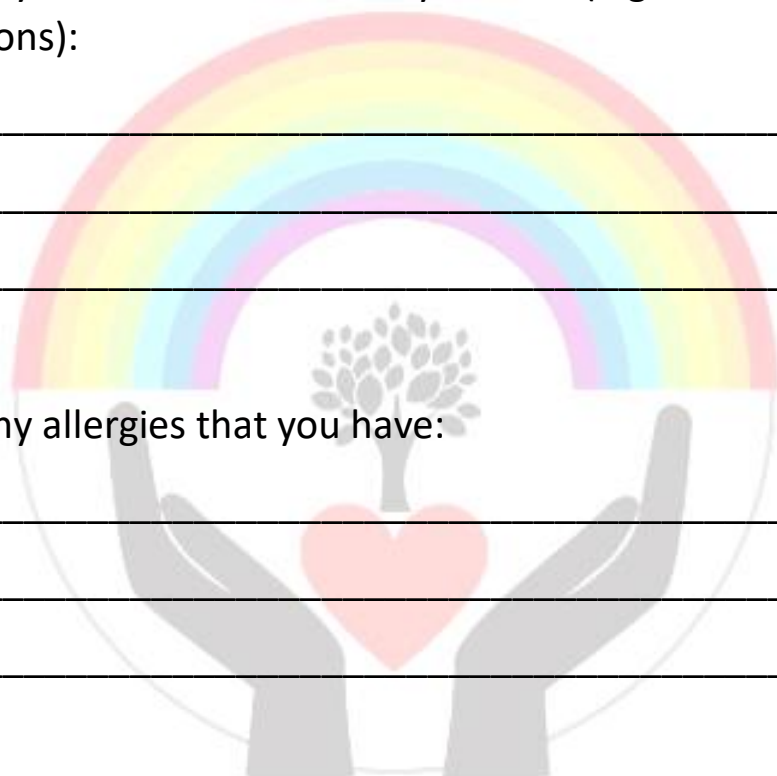
☐ Other _____

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 reaction 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?

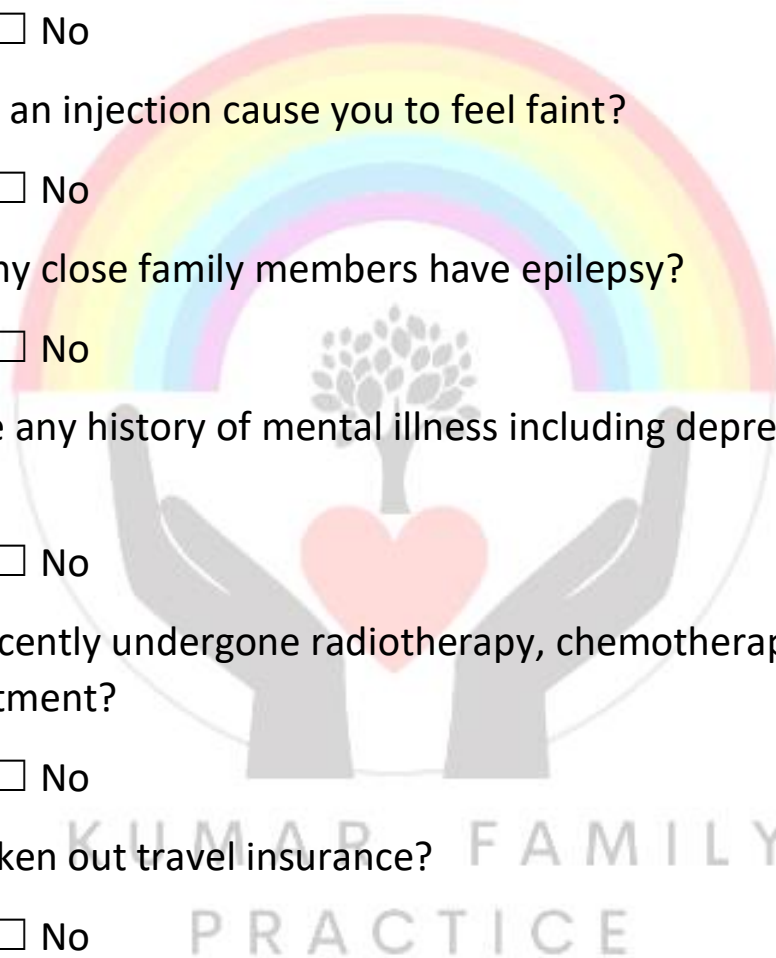
☐ Yes ☐ No

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

☐ Yes ☐ No

Are you pregnant, planning pregnancy or breast feeding?

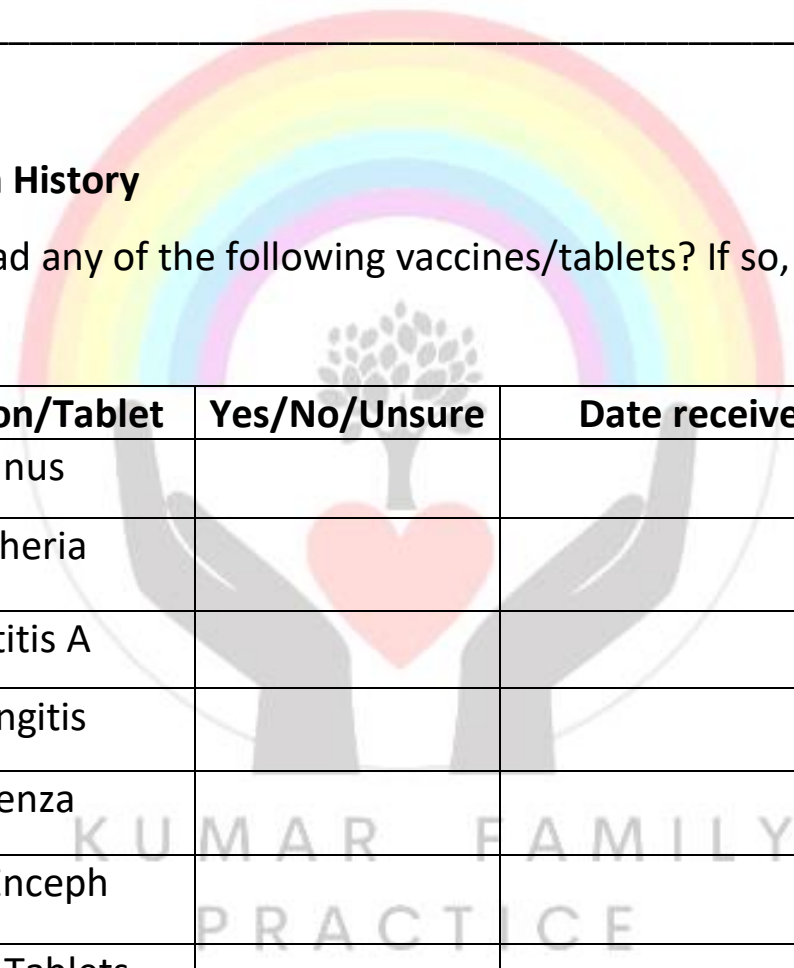
☐ Yes ☐ No



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		