Travel Questionnaire

Personal Details			
Name:		Sex:	Female ☐ Male ☐
Date of Birth:			
Daytime Tel:		Email:	

Trip Dates			
Departure Date:	(*dd/mm/yyyy*)	Duration:	

Itinerary and Purpose of Visit		
Country	Duration of Stay	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	