TravelQuestionnaire

PersonalDetails

Name:

Sex: ◉ Female ○ Male

DateofBirth:

Postcode:

DaytimeTel:

Email:

Trip Dates

Departure:

Duration:

Itinerary

Country	Duration	AvailabilityofMedicalHelp

TripDescription-pleasetickallappropriateboxes:

PurposeofTrip:	☐ Business	☐ Pleasure	☐ Other
Typeof Trip:	☐ Package	☐ Self-Organised	☐ Backpacking
	☐ Camping	☐ CruiseShip	☐ Trekking
Accommodation:	☐ Hotel	☐ Friends/Family	☐ Other
Travelling:	☐ Alone	☐ WithFriend/Family	☐ InaGroup
LocationType:	☐ Urban	☐ Rural	☐ Altitude
Activity Type:	☐ Safari	☐ Adventure	☐ Other

PersonalMedicalHistory

Listallchronicmedicalconditionsthatyouhave(eg.diabetes,heartorlungconditions)

Listallallergiesthatyouhave(eg.eggs,nuts,antibiotics)

Ifyouhavehadaseriousreactiontoavaccineinthepast,whichvaccinewasit?

Listallofyourcurrentmedications(includingoralcontraception)

Haveyourecentlysufferedfromanyinfection(e.gheavycold,fluorhightemperature)? ☐ Yes

Doeshavinganinjectioncauseyoutofeelfaint? ☐ Yes

Doyouoranyclosefamilymembershaveepilepsy? ☐

☐ Yes

Doyouhaveanyhistoryofmentalillnessincludingdepressionoranxiety? ☐ Yes

Haveyourecentlyundergoneradiotherapy,chemotherapyorsteroidtreatment? Yes

Haveyoutakenouttravelinsurance? ☐ Yes

Ifyouhaveamedicalcondition,haveyoutoldyourinsurancecompanyaboutit? ☐ Yes

Areyoupregnant,planningpregnancyorbreastfeeding? ☐

Yes

Writebelowanyfurtherinformationthatmightberelevant

VaccinationHistory

Haveyoueverhadanyofthefollowingvaccinations/tabletsandifso,when?

Tetanus	☐ Yes	Polio	☐ Yes
Diphtheria	☐ Yes	Typhoid	☐ Yes
HepatitisA	☐ Yes	HepatitisB	☐ Yes
Meningitis	☐ Yes	YellowFever	☐ Yes
Influenza	☐ Yes	Rabies	☐ Yes
JapBEnceph	☐ Yes	TickBorne	☐ Yes
MalariaTablets	☐ Yes	Other	