

Travel Questionnaire

Personal Details

Name: Sex: Female Male

Date of Birth: Postcode:

Daytime Tel:

E-mail:

Trip dates

Departure: Duration:

Itinerary

Country	Duration	Availability of Medical Help (<i>i</i>)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Past 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 and over the counter)

Have you recently suffered from any infection (eg, 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 or 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	<input type="radio"/> Yes	<input type="text"/>	Polio	<input type="radio"/> Yes	<input type="text"/>
Diphtheria	<input type="radio"/> Yes	<input type="text"/>	Typhoid	<input type="radio"/> Yes	<input type="text"/>
Hepatitis A	<input type="radio"/> Yes	<input type="text"/>	Hepatitis B	<input type="radio"/> Yes	<input type="text"/>
Meningitis	<input type="radio"/> Yes	<input type="text"/>	Yellow Fever	<input type="radio"/> Yes	<input type="text"/>
Influenza	<input type="radio"/> Yes	<input type="text"/>	Rabies	<input type="radio"/> Yes	<input type="text"/>
Jap B Enceph	<input type="radio"/> Yes	<input type="text"/>	Tick Borne	<input type="radio"/> Yes	<input type="text"/>
Malaria tablets	<input type="radio"/> Yes	<input type="text"/>	Other	<input type="radio"/> Yes	<input type="text"/>