# *Travel Questionnaire*

**­­Personal Details**

Name: OOOOOOOOOOOOOOOOOOOOOOOOOOOO Sex: Oo Female Oo Male

Date of Birth: OOOOOOOOOOOOOOOOOOOOOO Postcode: OOOOOOOOO

Daytime Tel: OOOOOOOOOOOOOOOOOOOOOO

Email: OOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOoooooooooooooooooooOOOOO

**Trip Dates**

Departure: OOOOOOO Duration: OoooooooOOOOOOO

**Itinerary**

Country Duration Availability of Medical Help *(I)*

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**Trip Description – Please Tick ALL appropriate boxes**

Purpose of Trip: Oo Business Oo Pleasure Oo Other

Type of Trip: Oo Package Oo Self-Organised Oo Backpacking

 Oo Camping Oo Cruise Ship Oo Trekking

Accomodation: Oo Hotel Oo Family/Friends Oo Other

Travelling: Oo Alone Oo With Friend/Family Oo In a Group

Location Type: Oo Urban Oo Rural Oo Altitude

Activity Type: Oo Safari Oo Adventure Oo Other

 **Personal Medical History**

List all chronic medical conditions that you have (eg. Diabetes, Heart or Lung Conditions) OOOOOOOOOOOOOOOOOO OOOOOOOOOOOOOoooooooooooooooooooOOOO

List all allergies that you have (eg. Eggs, Nuts or Antibiotics) OOOOOOOOOOOOOOOOOO OOOOOOOOOOOOOoooooooooooooooooooOOOO

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

List all of your current medications (including oral contraception) OOOOOOOOOOOOOOOOOO OOOOOOOOOOOOOoooooooooooooooooooOOOO

Have you recently suffered from any infection (eg. heavy cold, flu/high temperature)? Oo Yes Oo No

Does having an injection cause you to feel faint? Oo Yes Oo No

Do you or any close family members have epilepsy? Oo Yes Oo No

Do you have any history of mental illness including depression and anxiety? Oo Yes Oo No

Have you recently undergone radiotherapy, chemotherapy or steroid treatment? Oo Yes Oo No

Have you taken out travel insurance? Oo Yes Oo No

Are you pregnant, planning pregnancy or breast feeding? Oo Yes Oo No

If you have a medical condition, have you told your insurance company about it? Oo Yes Oo No

Write below any further information that might be relevant

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**Vaccination History**

Have you ever had any of the following vaccinations / tablets and if so, when?

Tetanus Oo Yes OOOOOOOOO Polio Oo Yes OOOOOOOOO

Diphtheria Oo Yes OOOOOOO OO Typhoid Oo Yes OOOOOOOOO

Hepatitis A Oo Yes OOOOOOOOO Hepatitis B Oo Yes OOOOOOOOO

Meningitis Oo Yes OOOOOOO OO Yellow Fever Oo Yes OOOOOOOOO

Influenza Oo Yes OOOOOOOOO Rabies Oo Yes OOOOOOOOO

Jap B Encephalitis Oo Yes OOOOOOOO O Tick Borne Oo Yes OOOOOOOOO

Malaria Tablets Oo Yes OOOOOOOOO Other Oo Yes OOOOOO O O O