**TRAVEL QUESTIONNAIRE**

**YOUR DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Date of Birth: |  |
| Tel No: |  | Sex: | Male / Female |
| Email address: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**TRIP DATES:**

|  |  |  |  |
| --- | --- | --- | --- |
| Departure Date: |  | Duration: |  |

**TRIP ITINERARY:**

|  |  |  |  |
| --- | --- | --- | --- |
| Country 1 |  | Duration: |  |
| Availability of medical help |  |
| Country 2 |  | Duration: |  |
| Availability of medical help |  |
| Country 3 |  | Duration: |  |
| Availability of medical help |  |

**TRIP DESCRIPTION (Please tick all appropriate boxes)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Purpose of Trip: |  | Business |  | Pleasure |  | Other |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Type of Trip: |  | Package |  | Camping |  | Backpacking |  | Cruise Ship |  | Trekking |  | Self-Organised |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Accommodation: |  | Hotel |  | With Friends/Family |  | Other |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Travelling: |  | Alone |  | With Friends/Family |  | In a Group |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Location Type: |  | Urban |  | Rural |  | Altitude |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Activity Type: |  | Safari |  | Adventure |  | Other |  |  |  |  |  |  |

**PERSONAL MEDICAL HISTORY:**

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

|  |
| --- |
|  |

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) or attach a repeat medication slip.

|  |
| --- |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you recently suffered from any infection (eg 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 |

Write below any further information that might be relevant

|  |
| --- |
|  |