

## PRE-TRAVEL QUESTIONNAIRE

### You

Surname		First Names			
Country of Birth		Male		Female	
ID Number		Tel (Home)			
Postal Address		Tel (Work)			
		Tel (Cell)			
Postal Code		Fax			
Employer		e-mail			
Next of Kin		Occupation			

### Medical History

Family History	Y	N	
Epilepsy or any other neurological problem	Y	N	

### Current Medical History

Asthma	Y	N	Indigestion	Y	N
Neurological Disorders	Y	N	Kidney Problems	Y	N
Epilepsy	Y	N	Migraine	Y	N
Psychiatric Disorders	Y	N	Psoriasis	Y	N
Cancer or Leukaemia	Y	N	Porphyria	Y	N
Heart Problems	Y	N	HIV	Y	N
High Blood Pressure	Y	N	Thymectomy	Y	N
Hepatitis	Y	N	Splenectomy	Y	N
Details			Previous Surgery Details		

### Allergies


### Have You:

### Are You:

Lost more than 5kg in last 12 months?	Y	N	Pregnant or planning to be?	Y	N
Been hospitalised recently?	Y	N	On any medical treatment?	Y	N
Do you weigh less than 45kg?	Y	N	Taking cortisone?	Y	N
Did you miss any of your childhood vaccinations?	Y	N	On oral contraceptives?	Y	N
Had blood tests for HIV?	Y	N	Using antibiotics?	Y	N
Do you have any health concerns about this trip?	Y	N			

### Partners:

### Chronic Medications


### Previous Vaccinations

<input checked="" type="checkbox"/>	BCG		<input checked="" type="checkbox"/>	Varicella	
<input checked="" type="checkbox"/>	Cholera		<input checked="" type="checkbox"/>	DTP+Hib+HepB	
<input checked="" type="checkbox"/>	Hepatitis A		<input checked="" type="checkbox"/>	Hepatitis A+B	
<input checked="" type="checkbox"/>	Hepatitis B		<input checked="" type="checkbox"/>	Influenza	
<input checked="" type="checkbox"/>	Japanese Encephalitis		<input checked="" type="checkbox"/>	Meningococcus A+C	
<input checked="" type="checkbox"/>	Meningococcus ACWY		<input checked="" type="checkbox"/>	MMR	
<input checked="" type="checkbox"/>	Polio (OPV/IPV)		<input checked="" type="checkbox"/>	Pneumococcus	
<input checked="" type="checkbox"/>	Rabies		<input checked="" type="checkbox"/>	Rubella	
<input checked="" type="checkbox"/>	Tetanus		<input checked="" type="checkbox"/>	Td Polio	
<input checked="" type="checkbox"/>	Typhoid (Oral/Injection)		<input checked="" type="checkbox"/>	Yellow Fever	
<input checked="" type="checkbox"/>	Childhood Vaccinations		<input checked="" type="checkbox"/>	Other	

### Your Trip

Purpose							
Holiday		Visiting		Business		Other	
Will you be undertaking any adventure activities?							
Scuba		Mountain Climbing		Piloting aircraft		Other	
Details							
List of countries you intend to visit							
Country/City		Departure Date		Return Date			
Country/City		Departure Date		Return Date			
Country/City		Departure Date		Return Date			
Areas to be visited							
Rural		Urban		Alt. >3000m		Beach	
Accommodation							
Hotel		Self-catering		Camping		Other	
Food/Drink							
Hotel		Restaurants		Stalls		Other	
How did you hear about us?	Advert		Travel Agent	Web		Word of mouth	Other
Signature				Date			

### Partners: