



# medical questionnaire

Please complete this questionnaire and return it with your booking form and registration fee. It is for your own safety that we find out as much as possible about your medical history. This will ensure that you can cope with the rigours of the trip. All your answers will be treated in the strictest confidence and will not necessarily adversely affect your chance to take part. We will attempt to accommodate everybody, but do reserve the right to refuse participation on medical grounds if we

feel your safety, and that of the group, may be compromised. Any decision made will be in consultation with you and your GP. Should any of your medical details change after you have completed this form then you must inform us.

Failure to divulge the full details of any medical condition from which you suffer will invalidate your insurance.

Please use BLOCK CAPITALS

## 1. Personal Details

Title \_\_\_\_\_ First name \_\_\_\_\_ Family name \_\_\_\_\_

Date of birth (dd/mm/yy) \_\_\_\_\_ Age \_\_\_\_\_ Mobile \_\_\_\_\_

Daytime phone no. \_\_\_\_\_ Evening phone no. \_\_\_\_\_

Name of your GP \_\_\_\_\_ Your GP's phone no. \_\_\_\_\_

Adventure name \_\_\_\_\_

## 2. Do you suffer or have you ever suffered from:

- | YES                      | NO                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Vertigo?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Altitude sickness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble and/or blood pressure problems?                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, bronchitis and/or shortness of breath?                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy and/or fainting attacks?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraine?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Severe head injury?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Back problems?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Fractures, tendon, ligament/cartilage damage?                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical or other disability?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric or mental illness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you attended hospital for any investigations/treatment in the last 2 years? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you suffering from or a carrier of any infectious diseases?                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you registered as disabled?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you suffer from any other conditions that are not stated above?               |

## 3. If you have answered yes to any of the above questions, please give further details below (use a separate sheet if required).

4. **Have you ever suffered from asthma? (Please tick)** Yes  No

If you answered yes to question 4, please give details below:

a) When was the last time you needed hospital treatment? \_\_\_\_\_

b) When was the last time you needed steroid tablets? \_\_\_\_\_

c) What medication/inhalers do you use? \_\_\_\_\_

\_\_\_\_\_

5. **Do you currently use any form of medication regularly? (Please tick)** Yes  No

If you answered yes to question 5, please give details below:

6. **Next of Kin (write clearly in BLOCK CAPITALS giving full name, address and telephone numbers)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Daytime phone no. \_\_\_\_\_ Evening phone no. \_\_\_\_\_

Mobile no. \_\_\_\_\_ Email \_\_\_\_\_

Participants must agree to inform Absolute Adventure of any medical or other condition that might affect their ability to take part in the event.

**In the event of an accident or illness while on the trip, I hereby give permission for Absolute Adventure medical or expedition staff to initiate medical treatment and to inform my next of kin in case of hospitalisation.**

**To the best of my knowledge this is a true and accurate description of my medical history and current condition. I understand that I am also responsible for informing Absolute Adventure of any change in my medical condition, including pregnancy, which may arise between now and the departure date. I understand that failure to do so will invalidate my insurance.**

Signature \_\_\_\_\_ Date (dd/mm/yy) \_\_\_\_\_

**TO BE COMPLETED BY THE FAMILY DOCTOR/PHYSICIAN  
WHO HAS ACCESS TO THE PATIENT'S MEDICAL HISTORY**

*This section ONLY needs to be completed if you are over 60 OR have answered 'YES' to any of the questions on the medical form.*

Participant Name \_\_\_\_\_

Adventure Name \_\_\_\_\_

The above named person will be participating in an adventure holiday during which time he/she will be subject to basic camping and living conditions. The physical activity on the adventure could last several hours per day and may be over rough or mountainous terrain. The adventure may also involve extremes of temperature, climate and altitude.

Participants may only have access to basic facilities, such as long drop (outdoor) toilets and primitive washing facilities. Many trips are in tented camps or basic lodges. Food is usually prepared over open fires and/or gas burners. Absolute Adventure ensures one leader per trip to provide basic first aid and to ensure hygiene standards are maintained. The adventure location may be a considerable distance from any hospital or medical back up.

Based on the above information, if there are any matters that you feel Absolute Adventure should be made aware of, please supply these on a separate sheet. If you require further details, please contact Absolute Adventure at : [info@adventure.ae](mailto:info@adventure.ae).

**I have read the participant's medical questionnaire and agree that the details are correct. In my opinion this patient is in a fit mental and physical state and capable of participating in the adventure described above.**

**Doctor's signature and practice stamp** \_\_\_\_\_

**Doctor's name (BLOCK CAPITALS)** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Telephone no.** \_\_\_\_\_ **Fax no.** \_\_\_\_\_

**Email** \_\_\_\_\_ **Date (dd/mm/yy)** \_\_\_\_\_