

# Medical Questionnaire

## Breast Cancer Care Overseas Challenges



(All information will be held in confidence by Breast Cancer Care and the tour operator)

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 trek/cycle. 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 the tour operator and Breast Cancer Care.

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

### 1. Personal details

Full Name			
Challenge destination & dates			
Date of birth		Age at time of challenge	
Blood Group (if known)	Weight	Height	
Daytime phone number		Evening phone number	
Name of your GP		Your GP's phone number	

### 2. Do you suffer or have you ever suffered from: Please circle/delete where appropriate

Vertigo?	YES / NO
Heart trouble and/or blood pressure problems?	YES / NO
Respiratory disease, Asthma, bronchitis and/or shortness of breath?	YES / NO
Diabetes?	YES / NO
Epilepsy and/or fainting attacks?	YES / NO
Migraine?	YES / NO
Severe head injury?	YES / NO
Back or joint problems?	YES / NO
Altitude Sickness?	YES / NO
Allergies? <b>(NB: mules are sometimes used on trek)</b>	YES / NO
Fractures, tendon, ligament/cartilage damage?	YES / NO
Physical or other disability?	YES / NO
Heat Stroke?	YES / NO
Cancer?	YES / NO
Psychiatric or mental illness? Anxiety or stress?	YES / NO
Have you attended hospital for <b>any</b> investigations/treatment in the last two years?	YES / NO
Are you suffering from or a carrier of any infectious diseases?	YES / NO
Are you registered as disabled?	YES / NO
Are you pregnant?	YES / NO
Do you smoke?	YES / NO
Do you suffer from any other conditions that are not stated above?	YES / NO

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

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 .....

### 4. Have you ever suffered from asthma? (Please circle) YES / NO

### 5. If you have answered 'yes' to question 4:

- 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?.....

### 6. Do you currently use any form of medication regularly? (Please circle) YES / NO

- a. If you have answered 'Yes' to Q6, please give details.....

### 7. Do you have any dietary requirements?.....

**NEXT OF KIN** (Please write clearly in capitals giving full name, address and telephone numbers)

Full Name		Relationship
Address		Daytime tel. no..... Evening tel. no..... Mobile no.....

In the event of an accident or illness while on the trip, I hereby give permission for our tour operators and Breast Cancer Care’s medical or expedition staff to initiate medical treatment and to inform my next of kin in case of hospitalisation. I understand by giving false information I endanger both my own safety and that of others on the trip. I agree to take with me sufficient supplies of medication needed for my current medical condition and for any condition which I had previously which may be reasonably expected to re-occur.

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 Breast Cancer Care and the tour operator 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. I agree to inform Breast Cancer Care and the tour operator of any medical or other condition that might affect my ability to take part in the event.

Signed		Date	
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**This section only needs to be completed if you are over 60 or have answered ‘YES’ to any of the questions on this medical questionnaire**

**THIS SECTION IS ONLY TO BE COMPLETED BY THE FAMILY DOCTOR/PHYSICIAN WHO HAS ACCESS TO THE PATIENT’S MEDICAL HISTORY**

The above named person will be participating in a charity fundraising trek/cycle during which time he/she will be subject to basic living conditions. Physical activity will involve trekking or cycling for approximately six to eight hours per day for five or six consecutive days at a pace to suit those of average fitness and set by the tour operator over rough, differing and often mountainous terrain. The trek/cycle may also involve extremes of temperature, climate and altitude (Peru only).

For participants taking part in **Trek China** the tour operator Kuoni Travel Ltd, will provide a qualified doctor either accompanying the group from the UK or a local doctor to give immediate first aid and ensure high hygiene standards are taught and maintained. The event may be some distance from any hospital/medical backup.

For participants taking part in Trek South Africa the tour operator Jenman African Safaris, will provide an English speaking doctor either accompanying the group from the UK the UK or a local doctor to give immediate first aid and ensure high hygiene standards are taught and maintained. The event may be some distance from any hospital/medical backup.

Based on the above information, if there are any matters that you feel Breast Cancer Care/ Kuoni Travel Ltd / or Jenman African Safaris should be made aware of, please supply these on a separate sheet. If you require any further details please call Sarah Johnson at Breast Cancer Care on 020 7960 3524.

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

Doctor’s signature		Date	
Doctor’s name (BLOCK CAPITALS PLEASE)			
Address	Practice stamp and GMC number		
Telephone Number			