IBRAHIM
TOURS

TRAVELER'S MEDICAL INFORMATION

FULL NAME (AS PER PASSPORT)	
DATE OF BIRTH (DD/MM/YYYY)	
BLOOD TYPE (IF KNOWN):	
HEIGHT & WEIGHT (IF KNOWN):	

EVALUATE YOUR GENERAL HEALTH (PLEASE CHECK THE APPROPRIATE BOX):

POOR	☐	**FAIR**	☐	**GOOD**	☐	**EXCELLENT**	☐

EVALUATE YOUR PHYSICAL CONDITION/STAMINA (PLEASE CHECK THE APPROPRIATE BOX):

POOR	☐	**FAIR**	☐	**GOOD**	☐	**EXCELLENT**	☐

HAVE YOU TAKEN OUT MEDICAL INSURANCE FOR THIS TOUR (PLEASE CHECK THE APPROPRIATE BOX)?

YES	☐	**NO**	☐	

DO YOU REQUIRE ANY TYPE OF TREATMENT ON A REGULAR BASIS (PLEASE CHECK THE APPROPRIATE BOX)?

YES	☐	**NO**	☐	

IF YOUR ANSWER IS YES, PLEASE DESCRIBE THE CONDITION:

.....
.....
.....
.....

Do you have, or have you had in the past 5 years, any of the conditions listed below? Please check the appropriate box.

CONDITION	YES	NO
High blood pressure		
Cardiac/heart disease, Coronary acute syndrome, Cardiac tamponade or any other		
Heart surgery		
Pulmonary conditions: Asthma/bronchitis, COPD-chronic obstructive pulmonary disease, pulmonary thrombosis		
Blood disorder: haemorrhage (excessive bleeding), clots, anaemia or any other		
Diabetes: Type 1 or Type 2		
Digestive disorder: stomach ache, stomach ulcers, heartburn, bleeding, constipation, diarrhoea, or any other		
Skin problem: sores, blisters, skin rash, burns, eruptions, itchiness or any other		

Allergies: dust, latex or any other		
Infectious/ contagious diseases		
Severe headaches - migraines		
Ear/nose/throat problems: hearing loss, earache, sinusitis, nosebleeds, or any other		
Restricted mobility/difficulty walking, use crutches, a walking stick or wheelchair		
Amputation		
Do you have a prosthesis or joint replacement?		
Fractures/dislocations		
Stroke		
Eye/vision problems: pain, dryness, redness, glaucoma, blurred vision, double vision or any other		
Autoimmune disorders: Lupus, Psoriasis, Celiac Disease(sprue) or any other		
Are you currently pregnant?		
Thyroid problems such as hypothyroidism /hyperthyroidism or any other		
Psychiatric disorders such as depression, anxiety or any other		
Tumours benign/malign: breast, lungs, intestine or any other		
Urinary system: pain, infections, prostatic hyperplasia (in men), kidney stones, renal failure or any other		
Spinal column and back problems: muscle contracture, herniated disk, sciatic nerve compression, spinal stenosis, scoliosis or any other		
Neurological disorders such as loss of consciousness, loss of memory/ balance problems (Alzheimer/Parkinson), epilepsy/seizures, dizziness/fainting or any other		
Musculoskeletal system: pain in joints, muscle pain, weakness, osteopenia/osteoporosis, swollen ankles/knees or any other		

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE DESCRIBE BELOW:

.....
.....

.....
.....

.....
.....

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS NOT MENTIONED ABOVE? PLEASE DESCRIBE BELOW:

.....
.....
.....
.....

DO YOU HAVE ANY MEDICAL ILLNESSES, DISABILITIES OR INFIRMITIES THAT REQUIRE THE REGULAR CARE OF A DOCTOR?

.....
.....

LIST ALL MEDICATIONS THAT YOU ARE TAKING AT THIS TIME, THE DOSAGES AND THE CONDITION THAT IS BEING TREATED:

MEDICATION	DOSAGE	WHAT ARE YOU TAKING THIS MEDICATION FOR?

HAVE YOU BEEN HOSPITALIZED OR HAD SURGERY IN THE LAST FIVE YEARS? IF YES, WHEN AND WHAT KIND OF SURGERY?

.....

.....

DO YOU HAVE ANY DRUG ALLERGIES? IF YES, WHAT ARE THEY?

.....

.....

DO YOU HAVE ANY DIETARY RESTRICTIONS OR FOOD ALLERGIES? IF YES, WHAT ARE THEY?
(WE ARE NOT RESPONSIBLE FOR THE FOOD WHILE YOU ARE TRAVELING WITH US DURING OUR TOURS, PLEASE MAKE SURE WITH THE RESTURANTS)

.....

.....

DO YOU HAVE ANY OTHER PHYSICAL OR MENTAL LIMITATIONS, OR HANDICAPS NOT MENTIONED ABOVE?

.....

.....

DO YOU HAVE ANY MOBILITY ISSUES THAT WOULD PREVENT YOU FROM COMPLETING THE UMRAH & HAJJ RITUALS?

YES	☐	**NO**	☐	

DO U HAVE WITH YOU ANY OF THE FOLLOWINGS TO HELP YOU DURING THE TOUR? (WE ARE NOT RESPONSIBLE TO PROVIDE ITEMS)

CANE	☐	**WALKER**	☐	**WHEELCHAIR**	☐	**PROSTHETIC LIMB**	

EMERGENCY CONTACTS	**NAME**	**RELATIONSHIP**	**PHONE NUMBER**
CONTACT 1:			
CONTACT 2:			

☐

☐

DOCTOR'S NAME (BLOCK LETTERS)	
NHS NUMBER:	
TELEPHONE:	**E-MAIL:**
ADDRESS:	