



MEDICAL INFORMATION

EXPEDITION/TREK:

DATES FROM:

TO:

SURNAME:

FIRST NAME:

Please have this form completed and signed by your usual medical practitioner. Please complete all pages of the form.

The information you provide is essential for your health and safety on the expedition. It will remain confidential and only be seen by the expedition leader and the expedition doctor unless it becomes essential to share it with guides higher up on the mountain. The decision to disclose medical information will be taken by the expedition leader if the need should arise. The information you give **will not** prevent you from taking part in the expedition. If you withhold any information pertaining to medical conditions that you have or have had, you are putting yourself and all other members of the expedition at risk.

DATE OF BIRTH:

GENDER:

WEIGHT:

HEIGHT:

BLOOD GROUP:

Do you or have you ever suffered from any of the following conditions?

- | | | |
|--|------------------------------|-----------------------------|
| • Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • High blood pressure | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Angina, Ischaemic heart disease or a heart attack | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Congenital heart defect or disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Migraines | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Stomach ulcers or gastritis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Haemorrhoids | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Blood clotting disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Mental illness; including anxiety and depression | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • HIV, Hepatitis B or C, or any other infectious disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you answered yes to any of the conditions above, please give details: date of diagnosis, type of treatment received and whether it is ongoing or not.

Have you ever had any operations? (including minor surgery, cosmetic surgery and laser treatment of myopia). If so, please give details and dates below.

Have you ever been in a major accident? If so please give details of the type of accident (traffic, climbing, skiing etc) and the injuries sustained by you.

Have you ever spent more than one night in hospital as a patient? If so please give details of the dates and the reason for admission.

Do you take **any** medications regularly? Please give details of name, generic name, dose and frequency below.

Do you have **any** allergies? (including food allergies and drug allergies).

Do you have any significant family history of illness or disease? (illness affecting your blood relatives).

Have you ever suffered from Acute Mountain Sickness, High Altitude Cerebral Oedema, High Altitude Pulmonary Oedema, frostbite or **any** other medical problem whilst at high altitude? Please give details of condition, dates, altitude at which the symptoms developed, treatment received and any ongoing problems related to that event or any recurrence of the same symptoms.

I confirm that the information provided in this form is correct and that I have withheld no information pertaining to my medical history.

Expedition member signature:..... Date:.....

Medical Practitioner signature:..... Date:.....

Contact details of Medical Practitioner

Name:
Address:
Telephone:
Email:

PLEASE RETURN BY EMAIL, FAX OR POST TO OUR ADMINISTRATION OFFICE:

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