TRAVEL MEDICINE QUESTIONNAIRE

Name___________________________________________         Date________________________
Employer ________________________________________      Business Phone _______________
Business Address __________________________________ Home Phone __________________

Travel Itinerary

Departure Date ________________________________    Return Date _______________________

1. Country _________________    Duration ___________________ Rural ________  Urban ______
2. Country _________________    Duration ___________________ Rural ________  Urban ______
3. Country _________________    Duration ___________________ Rural ________  Urban ______
4. Country _________________    Duration ___________________ Rural ________  Urban ______
5. Country _________________    Duration ___________________ Rural ________  Urban ______

Expected Travel Exposure(s)

Urban ____                 Evening Field Work ____   Ocean Water Exposure _____
Rural  _____                Fresh Water Exposure  _____       Scuba Diving ______
Other (Explain)  ________________________________________________________________

Accommodations

Hotel _____       Resort _____        Private Home ______       Camping  ______
Other (Explain)  _________________________________________________________________

Allergies

Drugs or Vaccines _________________________________________________________________
Other ___________________________________________________________________________

Do you take any of the following medications?  (Check all that apply)

β-blockers _____        Calcium Channel Blocker ______            Quinidine _______
Quinine _____                Other heart medications ____                 Anti-seizure medicine ______

Medications

List current prescription medicines___________________________________________________
________________________________________________________________________________

List current over-the-counter drugs (those used once a week or more) ______________________
________________________________________________________________________________

Female:  Check if you are pregnant or trying to become pregnant ______
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Medical History

Do you have a history of any of the following? (Check all that apply)

- Depression  
- Psoriasis  
- Seizure disorder or epilepsy  
- Hepatitis  
- Heart rhythm or conduction problem  
- Other psychiatric disorder  

List any current medical conditions for which you receive medical care (other than those listed above)

________________________________________________________________________________
________________________________________________________________________________

List any disorder of vision or eye abnormality

________________________________________________________________________________

Please answer Yes or No for the following questions.

?? Have you ever fainted after having an injection or your blood drawn? 
Yes  No

?? Have you ever had a very high fever or severe reaction from any vaccination? 

?? Do you have or do you live/work closely with anyone with any immune deficiency disorder or who is on chemotherapy or immunosuppression treatment? 

?? Do you have thrombocytopenia or a coagulation disorder? 

?? Are you prone to motion sickness? 

?? Any medical problems during previous travel? 

?? Do you desire assistance with jet lag? 

Please check any of the following agents to which you are allergic or cause a bad reaction.

- Aluminum  
- Eggs  
- Gelatin  
- Gentamicin  
- Mercury  
- Neomycin  
- Penicillin  
- Polymyxin  
- Streptomycin  
- Sulfur  
- Sulfites  
- Thimerosal  
- Yeast  

Date of most recent TB skin test ______________           Positive ____ or Negative ___

The Travel Medicine Health Care Provider shall list previous immunizations on the Immunization Record.

Additional questions or concerns of the traveler

________________________________________________________________________________
________________________________________________________________________________

Signatures ______________________________________         Date ___________________

(Traveler)__________________________________         Date ___________________

(Health Care Provider)_____________________________         Date ___________________