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Travel Health Questionnaire - Travel Information

Patient Name: _________________________________ Age_________ Date: ______________

Date Leaving the United States:		Duration of Travel:
Specific Itinerary		Please also include ANY stopover in Africa or South America
Dates	Country	City/State/Region
1.		
2.		
3.		
4.		

1. Purpose of Travel:								
2. Special Activities:								
Please check as appropriate below to best describe your trip (check all that apply)								
3. Accommodations:		Urban		Rural		Private Home		Camping
		First Class Hotel		Other Hotels		Hostels		Other:

Personal Medical History (Circle Yes or No)			
Y N	Immunosupression (HIV/AIDS, chemotherapy, radiation, recent steroids treatment, no spleen)	Y N	Thymus disorder (Myasthenia Gravis, DiGeorge Syndrome, surgery)
Y N	Depression, anxiety, other psychiatric disorders	Y N	Anemia (including sickle cell)
Y N	Cancer, Leukemia, Lymphoma	Y N	Diabetes
Y N	Medications/Injections that decrease immunity	Y N	Bleeding/clotting problems
Y N	Ear/Eye Problems	Y N	Seizures,Multiple Sclerosis or Gullian-Barre
Y N	Heart (including abnormal rhythm)	Y N	Skin conditions, psoriasis, eczema
Y N	Lung (asthma, emphysema, other)	Y N	Fainting with injections/blood drawn
Y N	Hepatitis, liver disease	Y N	Altitude sickness
Y N	Received blood, plasma or immune globulin in past 3 months	Y N	Gastrointestinal Problems, i.e. Crohns, ulcerative colitis, ulcers, reflux, other
Y N	Sick/fever or antibiotics in past 7 days	Y N	Insomnia, or experience nightmares
Y N	Kidney disease	Y N	Tuberculosis or tested positive for TB
Y N	Women: nursing, pregnant, planning pregnancy		Women: Date of Last Menstrual Period

Please explain marked answers above and include **other medical problems** and prior surgeries:

Allergy Information
Are you allergic to any of the following or have significant side effects? Check all that apply.

	Antibiotics		Seafood		Eggs		Mercury/thimerasol
	Vaccines		Insect bites		Latex		Other______________
Explain all checked:							I have no known allergies

List Current Medications (including non-prescription and supplements)

____

Vaccination History: Have you ever had any of the following vaccinations and if so when? Please bring a copy of your vaccine record and/or yellow card to your Travel Health appointment.

	Varicella (Chicken Pox) #1______ #2______ or disease_____				MMR #1________ #2________
	HepatitisB/Twinrix #1______ #2________ #3______				Hepatitis A #1______#2______
	Tetanus (Td/Tdap) booster ____		Influenza		Yellow fever
	Polio		Rabies		Meningococcal
	Typhoid		Other:		
	None				See Attached Vaccine Records

Did you complete all routine/required childhood vaccines? ❑Yes ❑No

Have you been on anti-malaria medication? ❑Yes ❑No If Yes, which one? _______________
If yes, did you have any adverse side effects? ❑Yes ❑No

The information above is accurate to the best of my knowledge.

Signature: ____ Date: ______________________

Print Name: ____