Travel Questionnaire

Last Name: _____ First Name: _____ Date of Birth: _____ Age _____

Sex: _____ Weight: _____ Place of Birth: _____

Home Phone: _____ Work: _____ Cell: _____ Email: _____

Address: _____

Today's Date: _____

Itinerary (Countries or Destinations):

1. _____ Dates in the location: _____
2. _____ Dates in the location: _____
3. _____ Dates in the location: _____
4. _____ Dates in the location: _____
5. _____ Dates in the location: _____

Date of Departure: _____ Date of Return: _____

Previous Travel: Country: _____ Date: _____

Country: _____ Date: _____

Trip Details (check all that apply): Travel with group ☐ Travel alone ☐ Urban ☐ Rural ☐ Farm ☐ Hotel-resorts ☐

Private Homes ☐ Youth Hostel ☐ Camping ☐ Safari ☐ High Altitude ☐

Travel by: Hiking ☐ Drive self ☐ Bus-Train ☐ Bicycling ☐ Cruise ☐ Fly ☐

Immunization History:	Yes	No
Have you ever fainted from having blood drawn of from an injection?	☐	☐
Have you ever had a fever or bad reaction/side effect from any vaccination? Which vaccination? _____	☐	☐
Do you live (or work closely) with anyone who has AIDS, and AIDS-like condition, any other immune disorder or is on chemotherapy for cancer?	☐	☐
Have you received any injection of immune globulin or any blood product during the past twelve months?	☐	☐

Allergies:	Yes	No
Are you allergic to any medications, vaccines, bee stings, yeast, eggs, gelatin, beef protein, soy, casein, lactose, phenol, formaldehyde, or protamine?	☐	☐
Do you have a history or hives or urticaria?	☐	☐

General Medical:	Yes	No
Do you have a medical condition that warrants maintenance medications of physician follow-up?	☐	☐
Have you had a fever in the past 48 hours?	☐	☐
Are you pregnant or might become pregnant on this trip?	☐	☐
Do you have AIDS, an AIDS-like condition, other immune disorder, leukemia, or cancer?	☐	☐
Have you ever had a convulsion, seizure, or epilepsy?	☐	☐
Do you have a problem with strange dreams and/or nightmares?	☐	☐
Do you have history of psychiatric problems?	☐	☐
Are you taking or will you be taking quinine, quinidine or medications for a cardiac conduction defect?	☐	☐
Do you have thymus disorder or myasthenia gravis?	☐	☐

If I have any chronic or acute medical condition including any listed above, I will check with my physician about care of my condition while traveling, and vaccine safety. Any problem listed above may be contraindication or merely a precaution that warrants further discussion between the health care provider and patient. The problem list is not all-inclusive but is representative of common issues that arise in a pre-travel consultation.

Signature (Traveler):_____ Date: _____

Immunizations Received

Please check all the vaccines that you have had in the past and list the date of the most recent vaccination known.

Flu Vaccine ☐	_____	Polio ☐	_____
Hepatitis A ☐	_____	Pneumococcal ☐	_____
Hepatitis B ☐	_____	Rabies Immunoglobulin/Vaccine ☐	_____
Herpes Zoster ☐ (Shingles)	_____	Tetanus ☐ (Tdap, Td, DTP, DTaP)	_____
Japanese Encephalitis ☐	_____	Typhoid ☐ (Oral or Shot)	_____
Meningococcal ☐	_____	Varicella (Chickenpox) ☐	_____
MMR ☐	_____	Yellow Fever ☐	_____

TB Skin Test: Positive ☐ Negative ☐

Quantiferon Test: Positive ☐ Negative ☐

T-Spot Test: Positive ☐ Negative ☐

Signature (Health Care Provider):_____ Date: _____