

Pre-Travel Questionnaire

Please complete all applicable questions to the best of your knowledge. If necessary, you may use the space at the end of this form to complete answers or provide additional information.

Patient _____ Last Name _____ First Name _____ Middle Initial _____

Sex M F Age _____ Date of Birth MM / DD / YYYY Social Security No. _____

Home Address: _____ Street _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Emergency Contact _____ Last Name _____ First Name _____ Relationship _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone _____

Primary Care Provider: _____ Last Name _____ First Name _____ Phone _____

Address: _____ Street _____ City _____ State _____ Zip Code _____

TRAVEL INFORMATION

Please list all countries and areas you will be visiting in chronological order with the dates of travel:

_____ Country _____ City/Province/Area _____ From: MM / DD / YYYY To: MM / DD / YYYY

_____ Country _____ City/Province/Area _____ From: MM / DD / YYYY To: MM / DD / YYYY

_____ Country _____ City/Province/Area _____ From: MM / DD / YYYY To: MM / DD / YYYY

_____ Country _____ City/Province/Area _____ From: MM / DD / YYYY To: MM / DD / YYYY

Please state the purpose of your trip (check all that apply):

- Business Vacation/Leisure Visiting Family/Friends Missionary
 Humanitarian Adventure Travel Adoption Other (specify) _____

Please state the anticipated travel conditions and activities (check all that apply):

- Organized Group Travel Independent Travel
 Hotel Cruise Ship Private Home
 Dormitory or Youth Hostel Camping Wilderness Areas (specify) _____
 Contact with Animals or Insects Providing Medical Care Doing Field Work
 Altitude (Greater than 8,000 feet) Swimming or Diving Physical Exertion (specify) _____
 Other High Risk Activities (specify) _____

Have you traveled previously to developing countries? Y N (specify) _____

Do you have medical evacuation insurance? Y N

Will your medical insurance cover illness or accidents abroad? Y N

MEDICAL INFORMATION

Are you presently in good health (any fever or infection)? Y N

If No, please describe: _____

Do you have any allergies? Y N

If Yes, please list and describe type of reaction:

Medications: _____

Environmental (for example, hay fever and pollen): _____

Bee or Wasp Sting: _____

Foods: _____

Eggs or Gelatin: _____

Other (specify): _____

If female, are you currently pregnant or do you plan to become pregnant in the next 3 months? Y N

Please list all medications you are using including vitamins, herbal supplements, and oral contraception:

Please check if you have or have ever had any of these conditions or treatments:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Kidney Failure or Dialysis | <input type="checkbox"/> Insulin Dependent Diabetes | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Digestive Tract Problems | <input type="checkbox"/> Heart Disease or Heart Attack | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Recent Surgery or Hospitalization | <input type="checkbox"/> Radiation or Chemotherapy | <input type="checkbox"/> Thymectomy | <input type="checkbox"/> Splenectomy |

Do you have cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohn's disease, or ulcerative colitis? Y N

Do you take cortisone, prednisone, or any other steroids, anti-cancer or immune suppressive drugs?

Y N

Do you live with anyone who may have a compromised immune system from any condition including, cancer, leukemia, organ transplant, or HIV / AIDS? Y N

Is anyone in your household pregnant? Y N

Please describe any special problems you anticipate while traveling, or health concerns you wish to discuss with the clinician: _____

IMMUNIZATIONS

Are you up to date on your childhood vaccines? Y N

Do you have an immunization record with you? Y N

When was your last tetanus shot? _____

Have you ever had a serious reaction to a vaccine in the past? Y N – list reaction _____

Have you received any vaccinations in the past 4 weeks? Y N

Vaccine

Hepatitis A 1 __, 2 __
 Hepatitis B 1 __, 2 __, 3 __
 Hepatitis A&B (Twinrix) 1 __, 2 __, 3 __, 4 __
 Influenza
 MMR (Mumps, Measles, Rubella) __ or Born In or After 1957 __
 Polio / IPV / OPV
 Pneumonia (Pneumovax)
 Typhoid Oral __, Injectable __
 Yellow Fever
 Japanese Encephalitis 1 __, 2 __, 3 __
 Meningitis (Meningococcal)
 Chickenpox (Varicella) Disease __ or Vaccines 1 __, 2 __
 HPV (Gardasil) 1 __, 2 __, 3 __
 Rabies 1 __, 2 __, 3 __
 Tetanus / Diphtheria
 Gamma Globulin
 PPD (Tuberculin Skin Test)
 BCG

Date of last immunization if applicable

MM / DD / YYYY
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ADDITIONAL INFORMATION

Please use this space to complete any of the above questions or provide other relevant information.

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient