

## 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.

### DEMOGRAPHICS

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 Address: \_\_\_\_\_

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 \_\_\_\_\_

How did you hear about LifeScape's travel clinic? \_\_\_\_\_

### 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

\_\_\_\_\_ 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 your condition:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_

**If female, are you currently pregnant or do you plan to become pregnant within 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:**

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

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

**Do you take cortisone, prednisone, or any other steroids, anti-cancer, or immunosuppressive medications?**  
 Y     N

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

**Is anyone in your household pregnant or trying to become 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  
Have you received any vaccinations during the past four weeks?  Y  N  
Have you ever had a serious reaction to a vaccination?  Y  N  
If Yes, please specify the vaccination(s) and describe the reaction(s): \_\_\_\_\_

**Vaccine**

**Date of last immunization if applicable**

Hepatitis A 1 \_\_, 2 \_\_ MM / DD / YYYY  
Hepatitis B 1 \_\_, 2 \_\_, 3 \_\_ MM / DD / YYYY  
Hepatitis A&B (Twinrix) 1 \_\_, 2 \_\_, 3 \_\_, 4 \_\_ MM / DD / YYYY  
Influenza (flu) MM / DD / YYYY  
MMR (Mumps, Measles, Rubella) \_\_ or born before 1957 \_\_ MM / DD / YYYY  
Polio / IPV / OPV MM / DD / YYYY  
Pneumonia (Pneumovax) MM / DD / YYYY  
Typhoid oral \_\_, injectable \_\_ MM / DD / YYYY  
Yellow Fever MM / DD / YYYY  
Japanese Encephalitis 1 \_\_, 2 \_\_, 3 \_\_ MM / DD / YYYY  
Meningitis (Meningococcal) MM / DD / YYYY  
Chickenpox (Varicella) disease \_\_ or vaccines 1 \_\_, 2 \_\_ MM / DD / YYYY  
HPV (Gardasil) 1 \_\_, 2 \_\_, 3 \_\_ MM / DD / YYYY  
Rabies 1 \_\_, 2 \_\_, 3 \_\_ MM / DD / YYYY  
Tetanus / Diphtheria MM / DD / YYYY  
Gamma Globulin MM / DD / YYYY  
PPD (Tuberculin Skin Test) MM / DD / YYYY  
BCG MM / DD / YYYY

**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