Pre-Travel Questionnaire Assessments Form

Patient age: ___________ **Gender:** ◯ Male ◯ Female

Medical History

Does you have or has he/she had any of the following?

- ◯ Diabetes mellitus
- ◯ Chronic cardiac condition; please specify: ____
- ◯ Chronic pulmonary condition; please specify: ____
- ◯ Renal disease
- ◯ Mental health/psychiatric illness; please specify: ____
- ◯ Thymus disorder (e.g., myasthenia gravis, DiGeorge syndrome, thymoma)
- ◯ HIV, AIDS, immune deficiency, or other immune disorder; please specify: ___________________
- ◯ Leukemia, cancer; please specify: ____
- ◯ Radical mastectomy or lymph---node dissection
- ◯ Convulsions, seizures, epilepsy
- ◯ Blood or clotting disorder
- ◯ None

Are you pregnant or breastfeeding or do you plan on becoming pregnant on this trip or soon afterwards?

◯ Yes ◯ No

Are you allergic to any of the following?

- ◯ Sulfa drugs ◯ Penicillin ◯ Yeast ◯ Gelatin
- ◯ Streptomycin, gentamicin, neomycin ◯ Latex ◯ Eggs or other foods: ___________

Medications

Are you on any of the following or have you taken any of these medications in the last 3 months?

- ◯ Blood thinners (e.g., warfarin, clopidogrel)
- ◯ Corticosteroids
- ◯ Chemotherapy or other anti---cancer medications; please specify: ____________________________
- ◯ Quinine, quinidine or other cardiac drugs; please specify: ____________________________________
- ◯ Antibiotics; please specify: ____
- ◯ Medications for mood disorders or emotional problems; please specify: _______________________
- ◯ Medications to control seizures or convulsions; please specify: ________________________________
- ◯ Any other prescription medication not indicated above; please specify: ________________________
- ◯ None

Travel History

List countries/regions that you have visited in the past:	**List any significant health outcomes/medical issues during this previous travel:**
____	____
____	____
____	____
____	____
____	____

Current Itinerary Details:

Date of Departure: ____________________ **Duration of Trip:** _____________________

List all countries/cities (in order) that the patient will be visiting(including transit stops):

Country 1: _________________ City/Region: ________________ Duration of stay: _________
Country 2: _________________ City/Region: ________________ Duration of stay: _________
Country 3: _________________ City/Region: ________________ Duration of stay: _________
Country 4: _________________ City/Region: ________________ Duration of stay: _________
Country 5: _________________ City/Region: ________________ Duration of stay: _________

Are there any recent travel advisories/outbreaks in these countries? If yes, please list:

____

Is there access to appropriate medical care in these countries? Please explain:

____

Are you travelling very soon ◯ Yes ◯ No

Are you travelling:

◯ Alone? ◯ With spouse/partner? ◯ With a group? ◯ With Children?

◯ With older/elderly persons?

What is the purpose of the travel?

◯ Pleasure/recreation ◯ Study ◯ Business ◯ Adventure ◯ Medical work
◯ Visiting friends and relatives (VFRs) ◯ Missions/humanitarian/relief/volunteer
◯ Other: ____

During travel, will you be:

◯ Hiking/trekking? ◯ Caving? ◯ Rafting/kayaking? ◯ In contact with animals?
◯ Spending time on a farm? ◯ At altitudes >2500 m? ◯ Scuba diving?

Where are you going to stay during your travels (i.e., urban vs. rural areas, types of accommodations, living conditions)?

____

Which mode(s) of transportation will you be using(e.g., train, within country flights, car, boat, motorbike, etc.)?

____

Do you have travel health/repatriation insurance? ◯ Yes ◯ No

VACCINATION RECORD HISTORY

Were you fully vaccinated as a child? ◯ YES ◯ NO

Have you had the following routine immunization/vaccines in the last 10 years? Check the () appropriate boxes.

Prior Immunizations:	YES	NO	Don't know	Approx Date			
Tetanus-Diphtheria	◯	◯	◯				
Polio	◯	◯	◯				
Act-HIB	◯	◯	◯				
Chicken Pox	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	
Rotatex/Rotarix	◯	◯	◯				
Measles, Mumps, Rubella	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	
Bexsero	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	**#3:**
Influenza vaccine (flu shot)	◯	◯	◯				
Gardasil	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	**#3:**
Dukoral	◯	◯	◯				
Hepatitis A	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	
Hepatitis B	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	**#3:**
Twinrix	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	**#3:**
Meningococcal	◯	◯	◯				
Injectable Typhoid	◯	◯	◯				
Oral Typhoid	◯	◯	◯				
Japanese Encephalitis	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	
Pneumonia vaccine Pn 13◯ Pr 23 ◯	◯	◯	◯				
Rabies Vaccine	◯	◯	◯	**Dose:**	**# 1:**	**#2:**	**#3:**
Tick Borne Encephalitis	◯	◯	◯				
Yellow Fever	◯	◯	◯				
Zostavax (Shingles)	◯	◯	◯				

Please bring in your old Immunization card.

I agree to stay seated in the waiting room for observation for 15 minutes after vaccination of all vaccines, with the exception of the yellow fever vaccine for which I will remain seated in the waiting room for 30 minutes after vaccination.

I declare that all information provided on this form is accurate to the best of my knowledge and that any inaccurate information may cause harm.

______________________________________ ______________________

Patient Signature **Date**

Please print this form and bring it with you on the day of your appointment