CONFIDENTIAL TRAVEL QUESTIONNAIRE

DATE:_____

NAME:_____ ID#:_____ DOB:_____

DESTINATION/ITINERARY: (List countries in order of travel)_____

_____

DEPARTURE DATE:_____ RETURN DATE:_____
PURPOSE OF TRAVEL:_____
WITH WHOM ARE YOU TRAVELING?:_____
LIVING/EATING ACCOMODATIONS: (check those that apply)
RURAL VILLAGE _____ URBAN RESORT _____ CAMPING_____ OTHER (describe)_____
PREVIOUS FOREIGN TRAVEL: YES____ NO____
IF YES, WHERE:_____

IMMUNIZATIONS & ALLERGIES

PREVIOUS TRAVEL IMMUNIZATIONS	SPECIFY DATES	PREVIOUS ROUTINE IMMUNIZATIONS
Yellow Fever_____		Measles_____
Immune Globulin_____		Mumps_____
Cholera_____		Rubella_____
Typhoid_____		Td/Tdap_____
Meningococcal_____		Polio_____
Hepatitis B_____		
Rabies_____		Flu_____
Anti-Malarial_____		PPD Test_____ Result_____
Hepatitis A_____		

Have you ever had any bad reaction or side effect from any vaccine? YES NO
If YES, specify_____

Do you currently have an acute illness or fever? YES NO

Are you allergic to:

Penicillin or sulfa?	YES	NO
Neomycin or streptomycin?	YES	NO
Any medication?	YES	NO
Mercury or thimerosal?	YES	NO
Aluminum or aluminum hydroxide?	YES	NO
Bee stings or any insect stings?	YES	NO
Yeast?	YES	NO
Eggs?	YES	NO

ANY OTHER ALLERGIES?_____

Do you have any specific questions or concerns?_____
_____

GENERAL MEDICAL

1. Are you currently taking any medication? YES NO

If yes, specify_____

2. Do you have any medical conditions? (e.g. diabetes, cardiac disease, etc.) YES NO

If yes, specify_____

3. Do you have any mental health conditions or concerns? YES NO

If yes, specify_____

4. Do you have an immune deficiency? (cancer, lymphoma, HIV) YES NO

If yes, specify_____

5. Are you currently being treated with steroids or chemotherapy? YES NO

6. Do you have a low platelet count or a coagulation disorder? YES NO

7. Have you ever had a seizure or convulsion or history of epilepsy? YES NO

8. Do you have Psoriasis? YES NO

9. Do you have any other health concerns to address? YES NO

If yes, specify_____

FOR WOMEN:

10. Do you take birth control pills or use any contraceptive method? YES NO

Specify,_____

11. Are you pregnant now, or any possibility you might be pregnant? YES NO

Last Menstrual Period;_____

12. Are you breastfeeding? YES NO

FOR CLINICAL STAFF USE

O: BP_____ Wt_____ P_____ Temp_____

General Appearance:
Eyes/Ears/Nose/Throat:
Heart:
Lungs:
Abdomen:
Skin:
Neck:

A: Health –Seeking for Foreign Travel

P: ___ Reviewed CDC Health/Travel Recommendations
___ Discussed Risks/Benefits of vaccines and malaria prophylaxis.
___ Rx's given_____
___ Vaccines administered (see also EMR)_____
___ Given copy of "Traveler's Companion" booklet for further travel health information.

Other: _____

Practitioner Signature:_____ **Date**_____