INTERNATIONAL TRAVEL MEDICAL QUESTIONNAIRE

Exact Name on Passport: ____

Today's Date: ___________________________ Date of Birth: __________________ Sex: ____________

Travel Itinerary (Country or countries): Please list in order of visit

Country & City/location	Arrival date	Depart date	Describe: urban or rural, activities, lodging plans

Reason for travel (circle all that apply): Mission Vacation Business Education Medical Other

List all allergies, sensitivities, medications, foods, etc. If none, please indicate by checking the box below:

Latex?____ **NO allergies or sensitivities**:

Have you ever had any reaction or side effect from any vaccination? Yes or No

If yes, explain: ____

Medication History: Please list all the medications you are currently taking, including over the counter medications, vitamins and minerals, and herbal supplements. You may continue to list on page 2 if necessary.

Medical History: Please circle yes or no answer for each question below

Are you currently ill (fever, headache, fatigue, nausea, vomiting, or diarrhea)?	Yes	No
Have you ever fainted from having your blood drawn or from an injection?	Yes	No
Do you live (or work closely) with anyone who has a deficiency of the immune system?	Yes	No
Do you have any deficiency of the immune system, or are you taking steroids, chemotherapy?	Yes	No
Is there a possibility you may be pregnant?	Yes	No
Do you currently have a fever over 101 degrees orally or an acute illness?	Yes	No
Are you on any anticoagulation medications or blood thinners?	Yes	No
Do you have a thymus disorder (thymomas, myasthenia gravis, thymectomy)?	Yes	No
Have you had a blood transfusion or Immune globulin in the past 6 months?	Yes	No
Have you had any surgical procedure in the past 6 months?	Yes	No
Do you have an allergy to egg, chicken protein, or gelatin?	Yes	No

Have you had or do you have any of the following conditions: Check all that apply

Fever in past 48 hours
Diabetes
Asthma / COPD
Psoriasis
Stomach / bowel problems
Kidney disease
Thyroid disease
High cholesterol

High blood pressure
Folic Acid deficiency
Liver disease
Rheumatoid arthritis
Eye disease / condition
Cancer, chemo, radiation
Joint swelling
Stroke

Heart disease (irregular heart beat)
Convulsions, seizures, epilepsy
Low platelet count/coag. Disorder
Tuberculosis / Lung disease
Depression/anxiety/psychiatric problems
Insomnia, nightmares
Numbness, tingling, weakness
Blood clots

Do you use tobacco currently or in the past? Yes or No   If yes, how many packs/cans per day? ________

Do you drink alcohol? Yes or No If yes, how many beverages (12 oz beer, 5 oz wine, or 1.5 oz liquor) per week? ____

Previous Vaccination History: Please indicate if you have ever received any of the following vaccinations by checking the appropriate box. If you have received any of the vaccinations below, please indicate what year they were administered:

Hepatitis A: I have received in the past – Yes or No If yes: Did you receive 2 doses? Yes or No	**Hepatitis B**: I have received in the past – Yes or No If yes: Did you receive 3 doses? Yes or No
Tetanus: I have received in the past – Yes or No Date received: ___________________	**Typhoid**: I have received in the past – Yes or No Date received: ___________________
MMR (Measles, Mumps, Rubella): I have received in the past – Yes or No	**Yellow Fever**: I have received in the past – Yes or No Date received: __________________
Polio: I have received in the past – Yes or No Have you received this as an adult? Yes or No	**Meningitis**: I have received in the past – Yes or No Date received: ____________________
Japanese Encephalitis: I have received in the past – Yes or No	**Rabies**: I have received in the past – Yes or No
Influenza: I have received in the past – Yes or No (flu shot) Date received: ___________________	**ZostaVax**: I have received in the past – Yes or No (shingles) Date received: ____________________

To the best of my knowledge, the questions on this form (pages 1 and 2) have been accurately answered. I understand that the information I provided above is used to for my medical health assessment in determining if medical services received by the Travel Clinic are safe and appropriate based on my current health status. I understand that providing incorrect information can lead to a delay in diagnosis and can be dangerous and potentially fatal to my health. It is my responsibility to inform the doctor's office of any change in my medical status.

____ ___________________________

Signature of patient or legal guardian   Date

____

Printed name of signature, if it is not the named patient

____ ________________________

Signature of Witness   Date

____

Printed name of Witness