INTERNATIONAL TRAVEL QUESTIONNAIRE

Date ___________________________ Name ___________________________
Phone (home) ___________________________ ID ___________________________ DOB ___________________________
(work) ___________________________ PCP ___________________________ MRN ___________________________

The answers you supply in this questionnaire will enable us to give the most accurate medical information
and advice for your specific travel plans. Please fill this out completely prior to your travel appointment.

Itinerary
Departure Date from United States: ___________________________ Return Date to United States: ___________________________
Is this trip: ☐ self-arranged ☐ personal group affiliated ☐ university affiliated
Are you anticipating any of the following during your trip: ☐ high altitude ☐ animal contact ☐ unsanitary conditions

Country #1 and duration of visit:

Purpose(s) of trip:
☐ pleasure / tourist ☐ humanitarian ☐ research / study ☐ business
☐ medical ☐ Peace Corps ☐ term / year abroad ☐ country of origin
Accommodation(s):
☐ affluent tourism ☐ urban ☐ rural ☐ wilderness ☐ family style ☐ dormitory style
Anticipated activities:
☐ medical ☐ education ☐ research ☐ tourist
☐ business ☐ safari ☐ adventure ☐ sport

Country #2 and duration of visit:

Purpose(s) of trip:
☐ pleasure / tourist ☐ humanitarian ☐ research / study ☐ business
☐ medical ☐ Peace Corps ☐ term / year abroad ☐ Country of origin
Accommodation(s):
☐ affluent tourism ☐ urban ☐ rural ☐ wilderness ☐ family style ☐ dormitory style
Anticipated activities:
☐ medical ☐ education ☐ research ☐ tourist
☐ business ☐ safari ☐ adventure ☐ sport

Please list any other countries you will be entering during this trip on another piece of paper.

Current Health
Date of last physical exam: ___________________________

Do you have any of the following active or chronic medical problems?

Neurologic ☐ Yes ☐ No Sickle Cell Disease ☐ Yes ☐ No Heart/circulatory ☐ Yes ☐ No
Thyroid ☐ Yes ☐ No Psychiatric ☐ Yes ☐ No Hypertension ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No Rheumatoid ☐ Yes ☐ No Asthma/lung ☐ Yes ☐ No
Cancer ☐ Yes ☐ No Urinary ☐ Yes ☐ No Joint/muscle ☐ Yes ☐ No
Splenectomy ☐ Yes ☐ No Genital ☐ Yes ☐ No Stomach/intestinal ☐ Yes ☐ No
Immune system ☐ Yes ☐ No

Please explain any medical problems “yes” answers from above:

________________________________________

________________________________________
Do you have:  
- impaired sight
- impaired hearing
- impaired mobility
- none of these

If yes, do you use:  
- corrective lenses
- hearing aids
- mobility items
- none

Do you have spare:  
- corrective lenses
- hearing aids
- mobility items
- none

Allergy or adverse reaction to any of the following? (check all that apply)
- Non prescription medication
- Prescriptions medications
- Vaccines
- Allergy injections
- Insect bites
- Seafood / shellfish
- Eggs
- None
- Other (including foods): ________________

Please explain any allergic / adverse reactions checked above: ________________

Do you carry or have you used Epinephrine (e.g. EpiPen) for emergencies?  
- Yes  
- No

Women only:

Do you use hormonal contraceptive?  
- Yes  
- No

Are you currently lactating?  
- Yes  
- No

Will you be lactating during your trip?  
- Yes  
- No

Please explain any “yes” answers: ________________

Immunizations

Were you born in the United States?  
- Yes  
- No  
- If no, where? ________________

Have you completed the following immunizations?  (include date(s) if known)

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Complete?</th>
<th>Dates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typhoid Oral</td>
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<tr>
<td>Pneumococcal</td>
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<td>Polio injectable</td>
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<td>MMR</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Flu</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Japanese Encephalitis</td>
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<tr>
<td>Meningococcal</td>
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<tr>
<td>Tetanus / Diphtheria</td>
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<tr>
<td>Other? (list &amp; dates)</td>
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</table>

Other? (list & dates) ________________

Previous diseases and infections possibly related to travel: Have you ever had

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Malaria</td>
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<td>Cholera</td>
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<td>Hepatitis C</td>
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<td>Giardia</td>
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<td>Dengue</td>
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<tr>
<td>Sickle Cell Disease</td>
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<tr>
<td>Dysentery</td>
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<td>Yellow fever</td>
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<tr>
<td>Other</td>
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<tr>
<td>Typhoid</td>
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<tr>
<td>Hepatitis A</td>
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<td>Hepatitis B</td>
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</table>

Please explain any previous diseases/infections checked above: ________________

Have you ever received INH or other tuberculosis medicine?  
- Yes  
- No  
- Unsure

Have you ever received a tuberculosis (PPD) skin test?  
- Yes  
- No  
- Unsure

If yes, date of your last test: ________________

Results:  
- Positive
- Negative

Past Medical History  
Please provide complete descriptions below or indicate NONE, if there is no relevant information.

Significant past medical history, including hospitalizations, surgeries, and chronic illness: ________________

Current medications, herbs or supplements: ________________