

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart/circulatory | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma/lung | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint/muscle | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Splenectomy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/intestinal | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Immune system | <input type="checkbox"/> Yes <input type="checkbox"/> 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 no

Allergy or adverse reaction to any of the following? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Non prescription medication | <input type="checkbox"/> Prescription medications |
| <input type="checkbox"/> Vaccines | <input type="checkbox"/> Allergy injections |
| <input type="checkbox"/> Insect bites | <input type="checkbox"/> Seafood / shellfish |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> None |
| <input type="checkbox"/> Other (including foods): _____ | |

Please explain any allergic / adverse reactions checked above: _____

Do you carry or have you used Epinephrine (eg EpiPen) for emergencies? Yes No

Women only:

Do you use hormonal contraceptive? Yes No Are you currently pregnant? Yes No
 Are you currently lactating? Yes No Will you be lactation 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)

Typhoid Oral <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	Typhoid injectable <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____
Pneumococcal <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	Polio (oral) <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____
Polio injectable <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	Yellow fever <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____
MMR <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____
Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	Rubella <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____
Flu <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____
Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	Rabies <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____
Japanese Encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates: _____
Meningococcal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Menactra or <input type="checkbox"/> Menomune	Dates: _____
Tetanus / Diphtheria <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Tdap or <input type="checkbox"/> Td	Dates: _____
Other? (list & dates) _____	

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

Malaria <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid <input type="checkbox"/> Yes <input type="checkbox"/> No
Cholera <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis C <input type="checkbox"/> Yes <input type="checkbox"/> No	Dysentery <input type="checkbox"/> Yes <input type="checkbox"/> No	Amebiasis <input type="checkbox"/> Yes <input type="checkbox"/> No
Giardia <input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Dengue <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No	

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: _____