Name: _____

Date of Birth: _____ /_____ /_____

Date: _____ /_____ /_____

International Travel Questionnaire

Please complete this form prior to being seen for your appointment.

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

ITINERARY

Date you are leaving the United States: _____ /_____ /_____

Date you are returning to the United States: _____ /_____ /_____

Please list all countries you will visit and dates you will be in each country (including layovers):

IS THIS TRIP:

- ☐ Self-arranged
- ☐ Affiliated with personal group
- ☐ Affiliated with university

PURPOSE OF TRIP:

- ☐ Vacation
- ☐ Education/Research
- ☐ Adoption
- ☐ Visit friends or family
- ☐ Missionary/volunteer/humanitarian relief
- ☐ Work (urban, office-based, conference)
- ☐ Work (rural, outdoors, or in local community)
- ☐ To obtain medical or dental care

ACCOMMODATIONS:

- ☐ Resort/large hotel
- ☐ Small hotel/guest house/B&B

☐ Cruise ship
☐ Private home (with locals)
☐ Private home (with relatives)
☐ Private home (expatriate or high-end)
☐ Primitive camping
☐ Up-scale camp/lodge
☐ Dormitory/hostel

WILL YOU BE VISITING AREAS THAT ARE:

Rural: ☐ Yes ☐ No ☐ Not Sure
Urban: ☐ Yes ☐ No ☐ Not Sure
Primitive or remote: ☐ Yes ☐ No ☐ Not Sure
Will you be ascending to high altitudes (8,000 ft or higher) : ☐ Yes ☐ No ☐ Not Sure
Will you be working with potential exposure to body fluids (e.g., medical or dental work)? :
☐ Yes ☐ No ☐ Not Sure
Will you be working with exposure to animals? : ☐ Yes ☐ No ☐ Not Sure

List any previous travel (Year/Destination): _____

_____

CURRENT HEALTH

Date of last physical exam: _____ /_____ /_____

HEALTH HISTORY

ALLERGIES:

No known drug allergies

☐ Antibiotics (e.g., penicillin, sulfa): _____

Side effects: _____

☐ Other medications: _____

Side effects: _____

☐ Egg
☐ Latex
☐ Gelatin
☐ Yeast
☐ Bees/wasps
☐ Seasonal

☐ Other: _____

Side effects: _____

CANCERS/BLOOD DISORDERS:

☐ Coagulation disorder
☐ History of cancer or blood disorder

☐ Other: _____

CARDIOVASCULAR:

☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
☐ Implanted pacemaker or automatic defibrillator
☐ Heart attack
☐ High cholesterol
☐ High blood pressure
☐ Stroke

☐ Other: _____

ENDOCRINE:

☐ Diabetes
☐ Thyroid disease

☐ Other: _____

GI:

☐ Crohn's disease or ulcerative colitis

☐ IBS

☐ GERD

☐ Chronic hepatitis

☐ Cirrhosis or liver failure

☐ Other: _____

IMMUNE SYSTEM:

☐ Steroids by mouth within last 3 months

☐ Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)

☐ Spleen removed

☐ Thymus disease or thymectomy

☐ HIV/AIDS

If yes

Most recent CD4: _____

Most recent viral load: _____

☐ Organ, bone marrow, stem cell transplant

☐ Other: _____

KIDNEYS:

☐ Dialysis

☐ Kidney insufficiency

☐ Other: _____

LUNGS:

☐ Asthma

☐ Emphysema/COPD

☐ Other: _____

MUSCULOSKELETAL:

☐ RA

☐ Psoriatic arthritis

☐ Other _____

NEUROLOGIC/PSYCHIATRIC

☐ Seizures or epilepsy

☐ Anxiety/depression

☐ History of Guillain-Barré

☐ Other: _____

SKIN:

☐ Psoriasis

☐ Other: _____

OB/GYN:

☐ Pregnant

If yes

How many weeks or what trimester: _____

☐ Breastfeeding

☐ Possible pregnancy in next 3 months

☐ Other: _____

VACCINATION HISTORY

(Please bring all vaccination records to your appointment)

Have you received the following immunizations?

Hepatitis A

Dose #1: _____

Dose #2: _____

Hepatitis B

Dose #1: _____

Dose #2: _____

Dose #3: _____

Meningococcal

Dose #1: _____

Dose #2: _____

Measles/Mumps/Rubella

Dose #1: _____

Dose #2: _____

Polio

Dose #1: _____

Dose #2: _____

Dose #3: _____

Dose #4: _____

Tetanus

Dose #1: _____

Typhoid

Dose #1: _____

Yellow Fever

Dose #1: _____

Japanese Encephalitis

Dose #1: _____

Dose #2: _____

Influenza

Latest dose: _____

COVID-19

Dose #1: _____

Dose #2: _____

Booster: _____

Please list any other vaccines received

Have you ever had an adverse reaction to an immunization?

If yes, please explain: