

TRAVEL CLINIC QUESTIONNAIRE

Please fill out this form and bring it with you to your Travel Clinic appointment.

- Bring with you any immunization records you may have.

You may have to check with previous health care providers to get all of this information.

(PLEASE PRINT)

Name:	Date of birth:	Sex: M/F
Address:	Social Security #:	

Please note below any diseases you have had, with dates, if possible. And list the vaccinations you have had and their dates.

Disease Name	Had Disease List Date if possible	Received Vaccines List Date Received
Measles (rubeola)		
Mumps		
Rubella (German measles)		
Chicken Pox (varicella)		
Hepatitis A		
Hepatitis B		
Typhoid		
Meningitis		

I. Have you received at least 3 doses of tetanus/diphtheria (Td) vaccine in the past (this includes DPT doses as a child)? II. When was your last tetanus/diphtheria shot given? III. Have you received at least 3 doses of polio vaccine, including childhood doses? IV. When was your last dose of polio vaccine?	I. (circle one) Yes / No II. _____ III. (circle one) Yes / No IV. _____
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Circle any of the following that you are allergic to:
 Eggs Thimerisol Sulfa Neomycin Streptomycin Bee stings

Other allergies:

Are you currently being treated for cancer? Yes / No

Do you have a deficiency of the immune system? Yes / No

PRINT

Patient Name:

Date of Birth:

Do you have any **existing medical conditions**, such as diabetes, heart disease, or lung disease? Please explain:

List all medications you are currently taking, either prescription or over-the-counter:

INFORMATION ABOUT YOUR TRAVEL PLANS:

Date of departure:

Length of trip:

Please indicate, in the order in which you will visit them, the **countries** to which you will be traveling. Also indicate length of stay in each country (bring complete details of itinerary to your appointment).

Is your travel to: urbanized areas / rural areas / urban and rural areas. (Please circle one)

What is the reason for travel (pleasure, business, medical work, etc.):

Business name and address:

How did you hear about our services?

QUESTIONS FOR WOMEN:

Are you pregnant, suspect you may be pregnant, or trying to become pregnant? Yes / No

Are you breast feeding? Yes / No

If pregnant, how many weeks?

Do you have any special concerns or questions to be answered at your appointment?