

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.

I understand that if any post-travel medical condition should occur (fever, nausea, vomiting, rash, etc.) I should check with my medical provider upon return.

TRAVEL PLANS

Purpose(s) of trip (check all that apply):

- vacation education / research adoption visit friends or family to obtain medical or dental care
 missionary / volunteer / humanitarian relief work (urban, office-based, or conference)
 work (rural, outdoors, or in local community) other: _____

Planned activities:

- hiking camping mountain climbing scuba diving caving
 other activities: _____

Will you be visiting areas that are:

- Rural yes no unsure
Urban yes no unsure
Primitive or remote yes no unsure

Will you be:

- Ascending to high altitudes (8,000 ft or higher)? yes no unsure
Working with potential exposure to body fluids (e.g., medical or dental work)? yes no unsure
Working with exposure to animals? yes no unsure
Potentially having new sexual partners? yes no unsure

Accommodation(s) (check all that apply):

- resort / large hotel small hotel / guest house / B&B cruise ship private home (with locals)
 private home (with relatives) private home (air conditioning; high end) primitive camping
 up-scale camp / lodge dormitory / hostel
 other accommodations: _____

Previous international travel (year and destination):

Departure Date from United States: _____ Return Date to United States: _____

Please list, IN ORDER, the countries, cities, towns or regions you will be visiting:

Country #1: _____

urban rural **Arrival/departure dates or duration of visit:** _____

Country #2: _____

urban rural **Arrival/departure dates or duration of visit:** _____

Country #3: _____

urban rural **Arrival/departure dates or duration of visit:** _____

Country #4: _____

urban rural **Arrival/departure dates or duration of visit:** _____

Country #5: _____

urban rural **Arrival/departure dates or duration of visit:** _____

Please add any other areas you will be visiting during this trip: _____

HEALTH HISTORY (check all that apply)

Allergies:

- antibiotics egg latex gelatin yeast bees / wasps seafood seasonal other medication allergies
 side effects / reactions from previous medications (e.g., hives, shortness of breath, nausea, dizziness, stomach upset or life threatening event)

Please explain any allergic / adverse reactions checked above: _____

Cancers / blood disorders:

- coagulation disorder history of cancer or blood disorder other

Please explain: _____

Cardiovascular:

- arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block) stroke
 implanted pacemaker or automatic defibrillator heart attack high cholesterol high blood pressure other

Please explain: _____

Endocrine:

- diabetes thyroid other

Please explain any allergic / adverse reactions checked above: _____

Gastrointestinal:

- Crohn’s disease or ulcerative colitis IBS GERD chronic hepatitis cirrhosis or liver failure other

Please explain: _____

Immune System:

- steroids by mouth within last 3 months spleen removed thymus disease or thymectomy organ, bone marrow, stem cell transplant (give details and dates below) immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab) HIV / AIDS (please write date and, if know, results, of most recent CD4 and most recent viral load in space below) currently living with someone who is immunocompromised other

Please explain: _____

Kidneys:

- dialysis kidney insufficiency other

Please explain: _____

Lungs:

- asthma emphysema / COPD other

Please explain: _____

Musculoskeletal:

- RA psoriatic arthritis other

Please explain: _____

Neurologic / psychiatric:

- seizures or epilepsy anxiety / depression history of Guillain-Barre’ other

Please explain: _____

Skin:

- psoriasis other

Please explain: _____

OB / Gyn:

- pregnant (please add below how many weeks pregnant you are or which trimester you’re in) breastfeeding
 possible pregnancy in next 3 months or plan to father taking oral combined birth control pill other

Please explain: _____

Previous diseases and infections possibly related to travel: Have you ever had any of the following?

- | | | | | | |
|-------------|--|---------------------|--|--------------|--|
| 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 | Dysentary | <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 medical problems “yes” answers from above:

VACCINATION HISTORY (please bring all vaccination records to your appointment)

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

- | | | | | | |
|---------------|--|---|-----------------------|--|-------------|
| Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates:_____ | Yellow fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates:_____ |
| Hepatitis B | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates:_____ | Influenza | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates:_____ |
| Meningococcal | <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:_____ | Rabies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates:_____ |
| Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates:_____ | Typhoid | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dates:_____ |
| Tetanus(TDAP) | <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:_____ | | |

Other? (list & dates) _____

Have you ever had an adverse reaction to an immunization? Yes No Unsure

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

Have you ever received a tuberculosis skin test (PPD) or Quantiferon blood test? Yes No Unsure

If yes, date of your most recent test: _____ Results: Positive Negative

CURRENT MEDICATIONS

Please list all current prescription medications as well as the reason for use / medical condition:

Please list all current non-prescription products you are using. List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc., and the reason for use / medical condition.

QUESTIONS / CONCERNS

Additional questions or concerns about your travel:
