



TRAVEL MEDICINE QUESTIONNAIRE
PLEASE PRINT

Legal Name of Traveler:				
Gender:		D.O.B.		Birthplace:
Primary Care Physician:				
ITINERARY				
Departure Date:		Return Date:		Length of Trip:
PURPOSE OF TRAVEL				
<input type="checkbox"/> Business	<input type="checkbox"/> Field Worked	<input type="checkbox"/> Relocation	<input type="checkbox"/> Teaching/Study	<input type="checkbox"/> Missionary Work
<input type="checkbox"/> Vacation	<input type="checkbox"/> Diving	<input type="checkbox"/> Safari	<input type="checkbox"/> Climbing	<input type="checkbox"/> Other
TYPE OF TRAVEL				
<input type="checkbox"/> Group/Tour		<input type="checkbox"/> Independent		<input type="checkbox"/> Fixed Itinerary
<input type="checkbox"/> Flexible Itinerary		<input type="checkbox"/> Cruise		<input type="checkbox"/> Other
ACCOMMODATIONS				
<input type="checkbox"/> Compound	<input type="checkbox"/> Hotel Resort	<input type="checkbox"/> Private Home	<input type="checkbox"/> Cruise Ship	<input type="checkbox"/> Other
DESTINATION. INCLUDING AIRPORT STOPOVERS. LIST IN ORDER OF TRAVEL:				
Country	City	Duration	Urban (X)	Rural (X)
HEALTH HISTORY				
Do you have myasthenia gravis? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have, or had, thymoma or thymus gland removal? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you prone to motion sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have an International Certificate of Vaccination (Yellow Card)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you ever fainted or had an adverse reaction to any of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Vaccines: <input type="checkbox"/> Yes <input type="checkbox"/> No		Bee Stings: <input type="checkbox"/> Yes <input type="checkbox"/> No		Blood Draws: <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have cancer, leukemia, AIDS, rheumatoid arthritis, lupus or other immune system problems? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you take Cortisone, prednisone, other steroids, anti-cancer drugs or have had radiation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you received a blood transfusion, blood products or immune globin in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you had any immunizations in the past 4 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please explain:				
MEDICATIONS (LIST ALL MEDICATIONS, INCLUDING DOSAGES)				
Prescription			Non-Prescription	
List medical conditions you have:				
Previous Surgery:				
Do you have a history of the following:				
Nightmares: <input type="checkbox"/> Yes <input type="checkbox"/> No		Psoriasis: <input type="checkbox"/> Yes <input type="checkbox"/> No		Seizure/Epilepsy: <input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric Disorders/Depression: <input type="checkbox"/> Yes <input type="checkbox"/> No			Stomach/Colon Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Women:				
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Planning pregnancy within 3 months: <input type="checkbox"/> Yes <input type="checkbox"/> No		Nursing: <input type="checkbox"/> Yes <input type="checkbox"/> No

I verify that the above information is complete and correct to the best of my knowledge:

Signature _____ Date _____

PLEASE BRING YOUR TRAVEL CARD OR IMMUNIZATION RECORD TO YOUR VISIT.