Travel Medicine Questionnaire

Name: _____DOB ____/____/___ Visit Date ____/____/___

Travel Itinerary

Destination Country(-ies)	Destination City(-ies)	Date of Departure	Date of Return

Purpose of travel: ☐ Business ☐ Pleasure ☐ Adventure ☐ VFR (Visiting Friends & Relatives)
☐ Mission/Relief Work ☐ Medical Tourism ☐ Combination
Type of travel: ☐ Independent ☐ Group/Tour
Types of areas to be visited: ☐ Urban ☐ Rural/Undeveloped
Lodging during travel: ☐ Large/Chain Hotel ☐ Budget Hotel ☐ Local Resident's Home ☐ Camping Out
Passport issued by: _____

Medical History

Please check all the following conditions that you currently have, or have ever been diagnosed as having, and provide details:

- ☐ A chronic medical condition for which you take medications or have routine follow-up treatment?
  Describe: _____
- ☐ A medical condition that is stable now, but may recur during travel?
  Describe: _____
- ☐ Heart condition:
  Describe: _____
- ☐ Respiratory condition:
  Describe: _____
- ☐ Allergies? Give details page 2.
- ☐ Gastrointestinal conditions:
  Describe: _____
- ☐ Epilepsy, convulsions/seizures or fainting spells?
  Describe: _____
- ☐ Psychiatric/emotional disorder?
  Describe: _____
- ☐ Anemia, abnormal bleeding or bruising?
  Describe: _____
- ☐ Immune disorder disease or due to medical treatment?
  Describe: _____
- ☐ Do you live or work closely with anyone who is immune-compromised? ☐ Yes ☐ No
- ☐ Prone to motion sickness? ☐ Yes ☐ No
- ☐ A fever in the past 24 hours? ☐ Yes ☐ No
- ☐ A history of thymus disorder or myasthenia gravis? ☐ Yes ☐ No
- ☐ For women:

Travel Medicine Questionnaire

Premise Health™

- When did your last menstrual period start? _____
- Are you currently breastfeeding? ☐ Yes ☐ No
- Are you now pregnant or attempting to become pregnant within the next three months? ☐ Yes ☐ No
- If pregnant, what is the due date? _____

☐ Please note any surgery and date:

_____

Medications

Are you currently taking any medications (including oral contraceptives, over-the-counter medications, supplements or antibiotics)? ☐ No ☐ Yes. If Yes, list below

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Allergies

Please list all medications (including vaccines), foods or other items to which you are allergic, or to which you have had a reaction, and describe the reaction.

Medication / Food / Other	Reaction

The following is a list of additives contained in various vaccines. Please check any to which you may be allergic or to which you may have had an adverse reaction.

☐ Aluminum/Aluminum Hydroxide
☐ Amphotericin B
☐ Benzethonium Chloride
☐ Chlortetracycline
☐ Eggs / Ovalbumin /Chicken Protein
☐ Formalin / Formaldehyde
☐ Gelatin
☐ Gentamicin
☐ Hydrocortisone
☐ Kanamycin
☐ Latex
☐ Neomycin
☐ Polymyxin B
☐ Protamine Sulfate
☐ Soy
☐ Streptomycin
☐ Thimerosal / Mercury
☐ 2-Phenoxyethanol
☐ Yeast Protein

Travel Medicine Questionnaire

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Immunization History

Please list all prior immunizations below: (If written patient records are available, photocopy or scan record to patient chart)

Vaccine	Date / Dose (As applicable)				
	# 1	# 2	# 3	Booster	Booster
Flu / Influenza					
Hepatitis A					
Hepatitis B					
Japanese Encephalitis					
Measles / MMR					
Meningococcal					
Pneumococcal					
Polio					
Rabies					
Rubella					
Tetanus / Td / Tdap					
Typhoid					
Twinrix (Hepatitis A & B Combo.)					
Varicella or history of Chickenpox					
Yellow Fever					
Other					
Tuberculin (TB) Skin Test	Date:		Result:		

I have answered this questionnaire truthfully and to the best of my ability.

Patient Signature _____ Date _____/_____/_____

NOTE: All information provided is maintained as confidential medical information in accordance with HIPAA laws.

Reviewed By: _____