

Travel Medicine Screening Questionnaire

Legal Name: _____ **Birth Date:** _____ **Date:** _____

Are you allergic or hypersensitive to any of the following? (Check all that apply)

- | | | | | |
|-----------------------------------|---|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Formaldehyde | <input type="checkbox"/> Gelatin | <input type="checkbox"/> Latex | <input type="checkbox"/> Yeast |
| <input type="checkbox"/> Aluminum | <input type="checkbox"/> Thimerosal/Mercury | <input type="checkbox"/> Bees/Wasps | <input type="checkbox"/> Neomycin | <input type="checkbox"/> 2-phenoxyethanol |

Do you have any other medication allergies (Sulfa, Erythromycin, Tetracycline, etc.)? Please list: _____

None

Have you ever had a bad reaction or side effect from any vaccination? Yes No

If yes, please explain: _____

Medications

Please list all the medications/injections you are currently taking, including over the counter medications and vitamins/minerals:

Medical History

- | | | |
|---|------------------------------|-----------------------------|
| Have you ever fainted from having your blood drawn or from an injection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you live (or work closely) with anyone who has cancer, HIV/AIDS, any immune disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have cancer, HIV/AIDS, any immune disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you taken steroids (i.e. Prednisone or Medrol) within the past 6 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any chemotherapy/radiation therapy in the past 6 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you taken any TNF Inhibitors? (Enbrel, Humira, or Remicade) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you smoke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you on Coumadin™ or Warfarin? (Blood thinners) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes: Date last INR: _____ INR value: _____

Have you had or do you currently have any of the following? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Fever in the past 48 hours | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Other psychiatric problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hepatitis / liver disease | <input type="checkbox"/> Eye disease/condition |
| <input type="checkbox"/> Arrhythmia (irregular heartbeat) | <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> G6PD deficiency |
| <input type="checkbox"/> Low platelet count/coagulation disorder | <input type="checkbox"/> Depression / anxiety | <input type="checkbox"/> Convulsion/seizures/epilepsy |
| <input type="checkbox"/> History of IBS | <input type="checkbox"/> History of Guillian Barre Syndrome | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> GI Disorders or Bleeding Gastric ulcer | <input type="checkbox"/> History of Thymus Gland removal | <input type="checkbox"/> Chronic bronchitis |
| <input type="checkbox"/> Other (including respiratory diseases) – Please specify: _____ | | |

For women only:

- Date of last menstrual period: _____
- | | | | |
|---|------------------------------|-----------------------------|---|
| Are you pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Post Menopause |
| Are you planning to become pregnant within the next year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not applicable |
| Are you using birth control measures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not applicable |
| Are you breastfeeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not applicable |

PLEASE TURN OVER TO COMPLETE

Itinerary

Date of Departure: _____

Length of travel: _____

Reason for travelling: Vacation Business Missionary/Healthcare School Trip

Destinations (in order of arrival): _____

Which of the following living accommodations will you be staying in? (check all that apply)

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Hotels | <input type="checkbox"/> Organized tented camps | <input type="checkbox"/> Cruise ship |
| <input type="checkbox"/> Hostels | <input type="checkbox"/> Camping on your own | <input type="checkbox"/> Dormitories |
| <input type="checkbox"/> Host/local homes | <input type="checkbox"/> Enclosed beach housing | <input type="checkbox"/> Orphanages |

Will your living accommodations have: (check all that apply)

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Screening? | <input type="checkbox"/> Mosquito netting? | <input type="checkbox"/> Air conditioning? |
|-------------------------------------|--|--|

What will be the source of your drinking water? _____

Residency History

What country were you born in? _____

Are you a US citizen? Yes No

Naturalization Year: _____

Have you ever lived outside of the US for any period of time? Yes No

Country/countries & length of stay: _____

Continuance of Care

Your Travel Nurse may need to prescribe medications for you. Please provide the name, address, and phone number of the pharmacy that you would fill your prescriptions at below.

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

If you would like the medical notes created for your visit today sent to your primary care physician, please provide his or her information below.

Primary Care Physician: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Office Use Only: Pharmacy not found; will add to directory. Initials: _____