Faculty Staff Clinic Travel Questionnaire
Please complete and bring with you to your clinic visit

Personal Information:
Name: __________________________ Age: _______ Weight: _________ Sex: ☐ M ☐ F
Birth date: ______________________ Email Address:

Referred by: ☐ Health Dept. ☐ Physician ☐ CDC ☐ Website ☐ Friend/Family
☐ Other:

Primary Care Physician:
________________________________________________________________________

Travel Information:

<table>
<thead>
<tr>
<th>Please list the countries you are traveling to:</th>
<th>Approximate length of stay in each country</th>
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<tr>
<td>Departure Date:</td>
<td>Return Date:</td>
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Reason for Travel:
☐ Tourist  ☐ Business  ☐ Student  ☐ Mission  ☐ Other

Accommodations:
☐ 1st Class Hotel  ☐ Budget Hotel  ☐ Youth Hostel  ☐ Family/House  ☐ Cruise
☐ Camping  ☐ Other

Do you plan to visit only tourist areas or major cities?  ☐ Yes ☐ No
Do you plan to visit rural areas?  ☐ Yes ☐ No
Do you plan to visit rural areas during evening or nighttime hours?  ☐ Yes ☐ No
Do you plan to go hiking or backpacking?  ☐ Yes ☐ No
Do you plan to go bicycling?  ☐ Yes ☐ No
Do you plan to go swimming?  ☐ Yes ☐ No
If yes, ☐ Chlorinated Pool  ☐ Fresh Water Lake or Stream  ☐ Ocean  ☐ Yes ☐ No
Do you plan to travel or to climb to high altitudes?  ☐ Yes ☐ No
Do you plan to scuba dive?  ☐ Yes ☐ No
   If yes, are you certified?  ☐ Yes ☐ No
When is air travel scheduled after last dive?  ☐ Yes ☐ No
Medical Information/History:

Do you have or had any of the following?

- Heart murmur, Rheumatic fever, Congenital heart lesions
- Heart disease, Hypertension, Heart failure, Angina
- Artificial heart valve, Heart pacemaker, Heart surgery
- Respiratory disease, Emphysema, Tuberculosis, Asthma, Hay fever
- Liver disease, Hepatitis, Jaundice
- Drug Addiction, Alcoholism
- Epilepsy fainting or dizzy spells, Nervousness, Psychiatric treatment
- Bruise easily, Bleeding problems
- Active cancer, Leukemia, Lymphoma or immune deficiency disease
- HIV disease or AIDS
- Receiving cancer chemotherapy, Immunosuppressive therapy, Radiation therapy, Prednisone
- Are or may be pregnant now or may become pregnant before or during your trip?
- Has your spleen been removed?
- Are you taking antibiotics now?
- Previous travel-related illnesses (please explain):

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<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Medication</th>
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Have your received immunoglobulin, a blood transfusion or other blood product within the **last 3 months**?  
- Yes  
- No

Allergies:

- Have had allergic reaction to eggs (can't eat eggs)
- Known allergy to thimerosol (a mercury derivative)
- Have fainted after shots
- Allergic reaction to any vaccines
- Allergy to any medications (list):
Immunization History:
Please Provide Approximate Dates:

☐ Typhoid (Oral) _________________  ☐ Rubella or Rubella Titer _______________
☐ Typhoid (Injectable) _______________  ☐ Mumps (meningitis) _______________
☐ Polio (Injectable) _______________  ☐ Menomune (meningitis) _______________
☐ Yellow Fever _______________  ☐ Immune (GammaGlobulin) _______________
☐ Measles (if born after 1957) _____________  ☐ Tetanus (within 10 years) _______________
☐ Mumps (if born after 1957) _______________

Hepatitis A
☐ Dose #1
☐ Dose #2
☐ Dose #3

Hepatitis B
☐ Dose #1
☐ Dose #2
☐ Dose #3

Hepatitis A/B (Twinrix)
☐ Dose #1
☐ Dose #2
☐ Dose #3

Japanese Encephalitis
☐ Dose #1 _______________
☐ Dose #2 _______________
☐ Dose #3 _______________

Varicella
☐ Illness _______________
☐ Vaccine #1 _______________
☐ Vaccine #2 _______________

The above information is correct to the best of my knowledge, I understand that some vaccines can cause serious or deadly illness when administered to someone infected with HIV, immunosuppressed, or pregnant. I have received written immunization information, all questions have been answered to my satisfaction and I give my consent to receive these immunizations.

Patient Signature ___________________________ Date

____________________________
Parent/Legal Guardian Signature ___________________________ Date

____________________________
Travel Medicine Nurse ___________________________ Date