Travel Questionnaire

Please bring these completed forms, all immunization records, and a complete list of medications with you to your visit.

**Personal Information:**
Name: ___________________________ Date of Birth: ____________ Age: _____ Gender: __ M __ F __ Other
Email Address: ________________________ Primary Care Physician (PCP): _______________________________________
Referred by: __ UA __ Health Dept __ Physician/PCP __ CDC __ Website __ Family or Friend __ Other

**Travel Information:**
Please list the cities/ports and countries to which you are traveling in the order you will visit them. Include all stopovers.

<table>
<thead>
<tr>
<th>City/Port/Country</th>
<th>Length of Stay in each Location</th>
<th>Type of Accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>______________________________</td>
<td>ressort, budget hotel, family/house (Airbnb, cruise, camping, other) – specify</td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>______________________________</td>
<td></td>
</tr>
</tbody>
</table>

**Purpose of travel** (check all that apply):
__ Pleasure/vacation
__ Business (type): ________________________________
__ Education/research
__ Moving/relocating
__ Visit family/friends
__ Volunteer/service/mission/humanitarian
__ Adoption
__ Obtain medical/dental care
__ Other: ________________________________

**Activities During Travel** (check all that apply):
__ Cruise ship
__ Camping
__ Hiking or trekking
__ Bicycling or motorcycling
__ Caving
__ Potential new sexual partners
__ High altitude (>8000 ft)
__ Swimming (specify type of water):
  __ Chlorinated pool
  __ Fresh water, lake or stream
  __ Ocean
__ Scuba diving
  Certified: __ No __ Yes
  Time to air travel after last dive: ____ hrs/days
__ Visit jungle area
__ Visit rural area or village
__ Visit farm
__ Work with animals
__ Work at orphanage
__ Medical or dental work (exposure to bodily fluids)
__ Be outdoors during evening or nighttime hours
__ Other: ________________________________
Travel Questionnaire

MR#______________

Medical Information:

Allergies:
Are you allergic to any of the following?
- __ Latex
- __ Gelatin
- __ Eggs
- __ Nuts
- __ Fish
- __ Shellfish
- __ Bee/wasp stings
- __ Sulfa drugs
- __ Penicillin
- __ Neomycin or streptomycin
- __ Thimerosal/mercury
- __ Other: ___________________________________

Do you need an Epi-pen for any of your allergies?
- __ No
- __ Yes

Medical History:

Please check the box if you have or have had any of the following:
- __ Eye or ear problems
- __ Skin conditions, psoriasis, eczema
- __ Heart murmur, rheumatic fever, congenital heart disease
- __ Heart disease, heart attack, angina, stroke
- __ Arrhythmia, hypertension, heart failure
- __ Artificial heart valve, pacemaker or defibrillator, heart surgery (stents or bypass)
- __ Respiratory disease, emphysema, asthma, hay fever
- __ Smoked in the past 10 years (cigarettes, cigars, pipes, marijuana, hookah, e-cig/vape)
- __ Problems with your thymus (different than thyroid), such as myasthenia gravis or DiGeorge syndrome
- __ Diabetes or thyroid disease
- __ Liver disease, hepatitis, jaundice, cirrhosis
- __ Reflux, GERD, ulcers, IBS, Crohn’s, ulcerative colitis
- __ Kidney disease, dialysis
- __ Drug addiction, alcoholism
- __ Seizures or epilepsy
- __ Fainting or dizzy spells
- __ Nervousness, anxiety, depression
- __ Guillain-Barre syndrome
- __ Vivid dreams or nightmares
- __ Other psychological conditions
- __ Arthritis, rheumatoid arthritis, fibromyalgia
- __ Bruise easily, bleeding problems (anemia, sickle cell)
- __ Active cancer, leukemia, lymphoma or immune deficiency disease
- __ Receiving cancer chemotherapy, immunosuppressive therapy, radiation, prednisone
- __ Organ, bone marrow, or stem cell transplant
- __ HIV disease or AIDS
- __ Positive TB skin test, treatment for tuberculosis
- __ Received immunoglobulin, blood transfusion, or blood products in the last 12 months
- __ Spleen removed
- __ Fever or antibiotics in the last 7 days
Travel Questionnaire

MR#________________  3 of 4

__ Motion sickness
__ Other medical conditions not listed above: ____________________________________________________________
__ Previous travel-related illnesses (please explain): ____________________________________________________________

Females Only:
Are you breastfeeding now?  __ No  __ Yes

Last menstrual cycle (first day/date): ____________  __ I do not have menstrual cycles

Contraception/birth control method: __ None  __ Condoms  __ Pills  __ IUD  __ Implant
__ Other: _______________________________________________________

Are you pregnant now?  __ No  __ Yes  __ Maybe
If yes, how many weeks? ____________
If no, is there a reason why you could not be pregnant now (uterus was removed; don’t have sex with men, etc.):
___________________________________________________________________________________________

Are you planning to become pregnant during your trip or within 6 months following?  __ No  __ Yes
If yes, when? ____________

Medications:
Please list all antibiotics, steroids/prednisone, chemotherapy, prescription medications, herbals, vitamins, and over-the-counter or nonprescription medications:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vaccination Reactions:
What meal(s) have you eaten so far today?  __ Breakfast  __ Lunch  __ Snack  __ Nothing

Have you ever ...
- fainted or felt light-headed from a shot?  __ No  __ Yes
- fainted or felt light-headed from having blood taken?  __ No  __ Yes
- had any unusual reaction to a vaccine?  __ No  __ Yes
Describe: ___________________________________________________________________________________

Vaccination History:
Did you have all your childhood vaccinations?  __ No  __ Yes  __ Not sure
Did you attend college or university in the USA?  __ No  __ Yes  What years? ____________
Travel Questionnaire

MR#__________________
4 of 4

Where were you born? ___ USA ___ Other country ________________________________

If you were born outside the USA:

At what age did you arrive in the USA? __________

Did you get vaccines for immigration? ___ No ___ Yes ___ Not sure

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Yes/No</th>
<th># Doses</th>
<th>Dates</th>
<th>Had the Disease? Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza (Flu)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles/Mumps/Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia 13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia 23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster (Shingles)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Yes/No</th>
<th>Last Dose (Year)</th>
<th>Vaccine Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus Booster (as adult)</td>
<td></td>
<td></td>
<td>__ Td</td>
</tr>
<tr>
<td>Polio Booster (as adult)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid</td>
<td></td>
<td></td>
<td>__ Oral (pills)</td>
</tr>
<tr>
<td>Meningococcal</td>
<td></td>
<td></td>
<td>__ MCV4</td>
</tr>
<tr>
<td>Japanese Encephalitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, or who is immunosuppressed or pregnant. I have received written immunization information, all questions have been answered to my satisfaction, and I give my consent to receive recommended immunizations. I will not hold University Medical Center or its staff responsible for any errors or omissions that I may have made in completing this form.

Patient Signature __________________________________________ Date ____________________

Parent/Legal Guardian Signature _____________________________ Date ____________________

Travel Medicine Provider _________________________________ Date ____________________