University Medical Center

Updated as of 4/19/17
Supersedes all prior versions

Travel Questionnaire

MR#_____

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.	**Length of Stay in each Location**	**Type of Accommodation** resort, budget hotel, hostel, family/house (Airbnb, cruise, camping, other) – specify
	__days __ wks	
	__days __ wks	
	__days __ wks	
	__days __ wks	
	__days __ wks	
	__days __ wks	
	__days __ wks	
	__days __ wks	
	__days __ wks	
	__days __ wks	

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: _____

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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

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__ 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:

Medication Name	Dose	Instructions

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? _____

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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

Vaccine	Yes/No	# Doses	Dates	Had the Disease? Yes/No
Influenza (Flu)				
Measles/Mumps/Rubella				
Hepatitis A				
Hepatitis B				
HPV				
Pneumonia 13				
Pneumonia 23				
Varicella (Chickenpox)				
Zoster (Shingles)				

Vaccine	Yes/No	Last Dose (Year)	Vaccine Type
Tetanus Booster (as adult)			__ Td __ Tdap
Polio Booster (as adult)			
Typhoid			__ Oral (pills) __ Injection (shot)
Meningococcal			__ MCV4 __ MenB
Japanese Encephalitis			
Rabies			
Yellow Fever			

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 _____