University Medical Center

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.	**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: ____________________________________

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

__ 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? ____________
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 ____________________