



## Travel Clinic Questionnaire

Date: \_\_\_\_\_ Date of Departure: \_\_\_\_\_ Duration of Trip: \_\_\_\_\_

<b>Destination(s)</b> List countries in the order you will be visiting them.	<b>Urban</b> (Check one or both)	<b>Rural</b>	<b>Length of stay</b>	<b>Purpose of trip</b> (e.g. business, trekking, tourism, etc.)
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

List all prescription and over-the-counter medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

List allergies to medications or foods (e.g. sulfa, eggs): \_\_\_\_\_  
\_\_\_\_\_

- |   |  |
|---|--|
| Do you have a history of heart conduction abnormalities or arrhythmias (rhythm disorders)?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any immune deficiency problems or are you taking cancer chemotherapy or steroids (e.g. Prednisone)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had a radical mastectomy or lymph-node dissection?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had chickenpox or the chickenpox vaccine?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a history of psoriasis?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a history of kidney or liver problems?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a history of seizures?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a history of depression, anxiety or other psychiatric conditions?                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a history of thymic gland disorders (e.g. thymus removal, myasthenia gravis, etc.)?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Will you be at altitudes greater than 10,000 feet?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Would you like antibiotics for travelers' diarrhea?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**For Women:**

- |   |  |
|---|--|
| Are you currently pregnant?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you planning a pregnancy during your trip or soon afterwards? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you breastfeeding?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**\*Note: Females receiving live vaccines should not become pregnant for three months.**

**Signature implies that the patient has provided all necessary medical information.**

Patient Signature \_\_\_\_\_