Careworks Convenient Healthcare
Pre-Travel Questionnaire

Name:___________________________________Date of Birth: _____/_____/_____
Home Phone:_____________________________Cell Phone:_____________________________
Home Address:____
____
Email Address: __________________________________
Marital Status:____________________Religion:____________________Race:______________

Trip Itinerary:
Departure Date: __________________________________
Length of Stay – Exact # of Days____________________days

Please list all countries and cities (if known) that you will visit on this trip in the order of travel:

1. __________________________________
2. __________________________________
3. __________________________________
4. __________________________________
5. __________________________________
6. __________________________________

What type of flight will you be taking?
Direct flight_____I will be stopping in/have layover in__________________________________

Have you traveled to any developing country before?	Yes____	No____
Have you traveled to this/these destinations before?	Yes____	No____
Do you have a passport?	Yes____	No____
Do you have a Visa?	Yes____	No____

Purpose of trip (check all that apply):

- ☐ Adoption
- ☐ Attending school or college
- ☐ Business
- ☐ Healthcare work
- ☐ Relocation
- ☐ Sporting event
- ☐ Vacation
- ☐ Visiting family/friends
- ☐ Volunteer work/missionary work
- ☐ Other:_________________________________

Where will you be staying (check all that apply)?

- ☐ City
- ☐ High altitude
- ☐ Jungle
- ☐ Remote area
- ☐ Rural area
- ☐ Woods
- ☐ Other:_________________________________

What type of accommodations will you be staying in (check all that apply)?

- ☐ Cabin (screened)
- ☐ Cabin (unscreened)
- ☐ Cruise ship
- ☐ Dorm
- ☐ Hotel (with/without air conditioning)
- ☐ Private residence/apartment
- ☐ Refugee camp
- ☐ Safari camp
- ☐ Tent
- ☐ Other:_________________________________

Who will you be traveling with?

- [ ] Alone
- [ ] Alone but with tour group
- [ ] Friends/family
- [ ] Spouse
- [ ] Church group
- [ ] School group
- [ ] Other:_______________________

What type of recreation will you be doing (check all that apply)?

- [ ] Backpacking
- [ ] Biking
- [ ] Camping
- [ ] Contact with animals
- [ ] Cruise
- [ ] Deep sea fishing
- [ ] Hiking
- [ ] Lake fishing
- [ ] Mountain climbing
- [ ] Rafting
- [ ] Safari
- [ ] Scuba diving
- [ ] Snorkeling
- [ ] Spelunking
- [ ] Surfing
- [ ] None:
- [ ] Other: _______________________

Allergies (list all):

- [ ] Bee stings
- [ ] Latex
- [ ] Food - Please list food allergies:____
- [ ] Medications – Please list medication allergies:____

Do you have any current or past medical history of (check all disease/conditions you may have):

Blood/Cancer

- [ ] Anemia
- [ ] Bleeding disorders
- [ ] Cancer of any type: __________________
- [ ] Chemotherapy/radiation
- [ ] Clotting disorders
- [ ] HIV/AIDS

Heart/Lung

- [ ] Asthma
- [ ] Cardiac conduction defect
- [ ] COPD
- [ ] Heart disease
- [ ] High blood pressure
- [ ] Irregular heart beat
- [ ] Lung disease
- [ ] Thymus disease

Immune System

- [ ] Autoimmune disorders
- [ ] Immunosuppression

Environmental

- [ ] Altitude illness
- [ ] Ear problems
- [ ] Motion sickness
- [ ] Seasonal allergies

Liver

- [ ] Alcoholism
- [ ] Cirrhosis
- [ ] G6PD deficiency
- [ ] Hepatitis

Skin

- [ ] Psoriasis

Stomach

- [ ] Colitis
- [ ] Colon problems
- [ ] Gastric reflux
- [ ] Heart burn
- [ ] Ulcers

Neurologic/psych

- [ ] Anxiety
- [ ] Depression
- [ ] Epilepsy
- [ ] Insomnia
- [ ] Nightmares
- [ ] Panic Attacks
- [ ] Seizures/convulsions
- [ ] Sleep disorders

Kidney

- [ ] Dialysis
- [ ] Kidney failure
- [ ] Urinary infections

Musculoskeletal

- [ ] Limited mobility
- [ ] Severe arthritis

Endocrine

- [ ] Diabetes
- [ ] Hyperthyroidism
- [ ] Hypothyroidism

Other:____

Do you live or work closely with anyone who has history of immune system deficiency or who is on chemotherapy? Yes____ No____

Have you received a blood transfusion and/or immune globulin in the past 12 months? Yes____ No____

Have you received any prednisone or steroids in the past 12 months? Yes____ No____

List any surgeries with date (month/year) if possible:

1. ____
2. ____
3. ____

List current medication with dosage and frequency:

1. ____
2. ____
3. ____
4. ____

Date of last medical exam: _____/_____/_____

Date of last dental exam: _____/_____/_____

Women:
Are you currently pregnant or trying to get pregnant? Yes____ No____
Are you breastfeeding? Yes____ No____
Date of last menstrual period: _____/_____/_____
Date of last GYN exam: _____/_____/_____
Type of birth control (please check):

- ☐ Condoms
- ☐ Injection
- ☐ IUD
- ☐ Patch
- ☐ Pill
- ☐ None
- ☐ Other:________________________

Have you had any reactions in the past to any vaccines: Yes____ No____

Do you have any allergies to any vaccines or components? Yes____ No____

Immunization history (please list all dates or attach record):

Childhood immunizations:
___________ Hepatitis B
___________ Influenza
___________ Meningitis (Menactra)
___________ Meningitis (Menomune)
___________ MMR
___________ Pneumococcal
___________ Polio
___________ Tdap (Adacel)
___________ Tetanus/Diphtheria booster
___________ Varicella

Travel Immunizations:
___________ Hepatitis A
___________ Injectable Typhoid
___________ Japanese Encephalitis
___________ Oral Typhoid
___________ Polio Booster (after age 18)
___________ Rabies
___________ Yellow fever

Reminders to bring with you:

1. Please bring current vaccine record with you. If you cannot find your vaccine record, you may check with:
   a. Parent
   b. Physician's office
   c. College/university health office
   d. High school/elementary school
2. If possible, review CDC travel information (www.cdc.gov/travel) for the countries to be visited. Write down any questions or concerns you may have, and bring them with you to your appointment.

International Travel Medical Questionnaire – 2007-2008

Immunizations	**Yes**	**No**
Any bad reaction/side effect from any vaccination?	☐	☐
Have you ever had hepatitis A or B?	☐	☐

General Medical	**Yes**	**No**	**Problem***
Do you have AIDS, an AIDS-like condition, any other immune disorder, leukemia, or cancer?	☐	☐	*MMR or components, Oral typhoid, Smallpox, Rabies, Varicella, Yellow Fever, Influenza (FluMist®), MMRV, Zoster Vaccine Live (Zostavax®)*
Have you had your thymus gland removed or a history of problems with your thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma?	☐	☐	*Yellow fever*
Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?	☐	☐	*any intramuscular injection*
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	☐	☐	*Mefloquine, DTaP, Tdap, MMRV*
Do you have any stomach conditions?	☐	☐	*Oral typhoid, Mefloquine, Doxycycline, Malarone, Chloroquine*
Do you have a G6PD deficiency?	☐	☐	*Chloroquine, Primaquine*
Do you have severe renal impairment?	☐	☐	*Malarone*
Bowel confition such as diarrhea or constipation?	☐	☐	*Rotavirus*
Have you ever had hepatitis or yellow jaundice?	☐	☐	
Do you have a history of psychiatric problems?	☐	☐	*Mefloquine*
Do you have a problem with strange dreams and/or nightmares?	☐	☐	*Mefloquine*
Do you have insomnia?	☐	☐	*Mefloquine*
Do you have problems with vaginitis?	☐	☐	*any antibiotic*
Do you have psoriasis?	☐	☐	*Chloroquine or related compounds*
Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis (e.g., Itchy, red, scaly rash lasting > 2 weeks that often comes and goes)?	☐	☐	*Smallpox*
Cardiac disease, with or without symptoms?	☐	☐	*Smallpox, Influenza (FluMist®)*
Do you have any eye conditions?	☐	☐	
Are you prone to motion sickness?	☐	☐	

Medications ARE YOU TAKING OR WILL YOU BE TAKING:	**Yes**	**No**	**Problem***
• medications for a cardiac conduction defect?	☐	☐	*Mefloquine*
• chloroquine, mefloquine, or proguanil to prevent malaria?	☐	☐	
• proguanil to prevent malaria?	☐	☐	*Oral typhoid*
• Pepto-Bismol® to prevent traveler's diarrhea?	☐	☐	*Doxycycline, tetracycline*
• antacids?	☐	☐	*Doxycycline, tetracycline*
• aspirin therapy? (children & adolescents)	☐	☐	*Varicella, Influenza (FluMist®)*
• medications for emotional problems?	☐	☐	*Mefloquine*
• medication for convulsions?	☐	☐	*Mefloquine*

Allergies	**Yes**	**No**	**Problem***
ARE YOU ALLERGIC TO:			
• any medications?	☐	☐	
• Amphotericin B?	☐	☐	*Rabies (PCEC)*
• penicillin or sulfa?	☐	☐	*Diamox®, Fansidar®, Penicillin, Sulfa*
• mercury or thimerosal? (Only vaccines containing more than a trace amount of thimerosal are listed.)	☐	☐	*DT (multi-dose), Tetanus toxoid (multi-dose; booster), Influenza (Fluzone multi-dose; Fluvirin), Japanese encephalitis, Meningococcal (Menomune multidose)*
• Aminoglycoside antibiotics? (streptomycin, neomycin, kanamycin, gentamicin)	☐	☐	*Hepatitis A/B (Twinrix®), Influenza, IPV, MMR or components, Rabies (HDCV and PCEC), Varicella, Zoster Vaccine Live (Zostavax®), Smallpox, PEDIARIX™, MMRV, TBE*
• polymyxin?	☐	☐	*Influenza (Fluvirin®), IPV, Smallpox, PEDIARIX™*
• sulfites?	☐	☐	*Doxycycline*
• aluminum or aluminum hydroxide?	☐	☐	*Hep. A, Hep. B, Hep. A/B (Twinrix®), COMVAX™, DTaP, Td, Rabies (RVA), Anthrax, Pneumococcal (PVC), Tdap TBE, HPV (Gardasil®)*
• benzethonium chloride?	☐	☐	*Anthrax*
• 2-phenoxyethanol?	☐	☐	Hep. A (Havrix®), Hep. A/B *(Twinrix®), IPV, DTaP (Infanrix™ , PEDIARIX™), Tdap (ADACEL™)*
• bee stings or history of hives or urticaria?	☐	☐	Japanese encephalitis
• yeast?	☐	☐	Hep. B, Hep. A/B *(Twinrix®),PEDIARIX™ HPV (Gardasil)*
• Eggs?	☐	☐	*Influenza, Rabies (PCEC), Yellow fever, MMR or components, MMRV, TBE*
• Glycerin or chlortetracycline?	☐	☐	*Smallpox*
Are you hypersensitive to gelatin?	☐	☐	*Varicella, Japanese encephalitis, MMR or Componenets, DTaP, Yellow fever, Rabies (PCEC), Influenza (Fluzone), Oral Typhoid, MMRV, Zoster Vaccine Live (Zostavax®)*
Are you hypersensitive to beef protein, soy casein, lactose, phenol, or formaldehyde?	☐	☐	*IPV, Meningococcal, Typhoid, Rabies, DTaP, Pneumococcal (PPV), Anthrax, Smallpox, Tdap, MMRV, Rotavirus, TBE*

*Note: *Any “problem” listed above may be a contraindication or merely a precaution that warrants further discussion between the health care provider and patient. The “problem” list is not all-inclusive but is representative of common issues that arise in a pre-travel consultation.*

SIGNATURES:______________________________ (Traveler and Date)

______________________________ (Health Care Provider and Date)