

Travel Clinic Screening Questionnaire

Legal Name: _____ **DOB:** _____ **Date:** _____

Are you allergic or hypersensitive to any of the following? (Check all that apply)

- | | | | | |
|-----------------------------------|---|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Formaldehyde | <input type="checkbox"/> Gelatin | <input type="checkbox"/> Latex | <input type="checkbox"/> Yeast |
| <input type="checkbox"/> Aluminum | <input type="checkbox"/> Thimerosal/Mercury | <input type="checkbox"/> Bees/Wasps | <input type="checkbox"/> Neomycin | <input type="checkbox"/> 2-phenoxyethanol |

Any other medication allergies,(Sulfa, Erythromycin, Tetracycline etc) please list:

Have you ever had a bad reaction or side effect from any vaccination? yes no

If yes, please explain: _____

Medications

Please list all the medications/injections you are currently taking, including over the counter medications and vitamins and minerals:

Medical History

Have you ever fainted from having your blood drawn or from an injection? yes no

Do you live (or work closely) with anyone who has cancer, HIV/AIDS, any other immune disorder? yes no

Do you **have** cancer, HIV/AIDS, any other immune disorder? yes no

Have you taken steroids (i.e. Prednisone, Medrol) within the past 6 months? yes no

Have you had any chemotherapy/Radiation therapy in the past 6 months? yes no

Any TNF Inhibitors? (ENBREL, HUMIRA, or REMICADE) yes no

Are you on Coumadin™ or Warfarin? (Blood thinners) yes no

Date last INR: _____ **INR value:** _____

Have you had or do you currently have any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Fever in the past 48 hours | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Other psychiatric problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hepatitis / liver disease | <input type="checkbox"/> Eye disease/condition |
| <input type="checkbox"/> Arrhythmia (irregular heartbeat) | <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> G6PD deficiency |
| <input type="checkbox"/> Low platelet count/coagulation disorder | <input type="checkbox"/> Depression / anxiety | <input type="checkbox"/> Convulsion/seizures/epilepsy |
| <input type="checkbox"/> History of IBS | <input type="checkbox"/> History of Guillian Barre Syndrome | |
| <input type="checkbox"/> GI Disorders or Bleeding Gastric ulcer | <input type="checkbox"/> History of Thymus Gland removal | |

Do you: Smoke? **Y/N** Have Asthma? **Y/N** Have Chronic Bronchitis? **Y/N**

Other Respiratory diseases: _____

Women Only

Are you pregnant? yes no **Date of last menstrual period:** _____ post menopause

Are you planning to become pregnant within the next year? yes no N/A

Are you using birth control measures? yes no N/A

Are you breastfeeding? yes no N/A

PLEASE TURN OVER TO COMPLETE

ITINERARY

Date of Departure: _____ Length of Stay: _____

- Vacation Business Missionary/Healthcare School Travel
- Will you stay in: Hotels Hostels Host/Local Homes Organized Tented Camps Enclosed Beach Housing
- Orphanages Dormitories Cruise Ship Camping on your own

Will your housing have: Screening? Air Conditioning? Mosquito Netting?

What will be the source of your drinking water?

Birth Country _____

US Citizen Y___ N___ Naturalization Year _____

Have you ever lived outside of the US for any period of time? If so, where/how long? _____

Destination(s): (Please list all the countries you will be visiting in the order that you will be visiting them)
