

# Travel and Health History Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Date of Departure: \_\_\_\_\_

## Travel Destination Information

Location of Each Stop	Duration (Days/Weeks)	Type of Locale <i>Rural, urban, mountains, Coast/beaches, jungles, Forest, wilderness</i>	Type of Accommodations <i>Hotel, motel, resort, camping Homestays, wilderness</i>

Have you ever had any allergic reactions to medications or food? \_\_\_\_\_

## Past and/or current health problems

Health Problem	No	Now	Prior	Health Problem	No	Now	Prior
Bronchial Asthma				Depression*			
Heart Disease				Anxiety Disorders*			
Heart Rhythm Disturbance				Mental Health Issues*			
Cancer				Emphysema/COPD			
Liver Disease				Diabetes/Insulin?			
Hepatitis A				Leukemia			
Hepatitis B				Splenectomy			
Kidney Disease				Radiation			
Nervous System Disease				Immune System Disease			
Lung Disease				Seizures			
Stomach Disease				G-6-PD Deficient			
Pregnancy				*This info needed to plan for antimalarial drug prescriptions and possible side effects			
Planning pregnant within 3 Months of your trip?							

Please list any medications you have taken in the past 2 weeks: \_\_\_\_\_

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## Activities

Special activities you are planning may affect decisions about travel immunizations, medications, or information.

Activity	Yes	No
Any activity requiring fine-tuned balance including piloting, mountain or rock climbing, or operating heavy equipment?		
Outdoor activities between dusk and dawn?		
Delivering health care?		
Intentionally using local health care? (i.e. acupuncture)?		
Tattooing or other risk of exposure to body fluids?		
Close exposure to animals or providing veterinary care?		
Cave exploration? Spelunking?		
Activities at elevations above 9,000 – 10,000 feet		
Activities potentially involving motion sickness?		
Possibility of other risky behaviors?		

## Health History

Aspects of your past and current health status may also affect decisions about travel immunizations, medications, or information appropriate for you. Please review the following decisions on vaccination history, allergies, health problems, medications, and pregnancy. Check any that apply to you:

Have you had any of these vaccinations?	Yes	No	?	Date of most recent vaccination
Cholera				
Diphtheria/Tetanus				
Gamma globulin or Immune globulin				
Hepatitis A				
Hepatitis B				
Influenza ("flu")				
Measles, Mumps, Rubella (MMR)				
Meningococcal/Meningitis				
Pneumovax				
Polio, Injected Form				
Polio, Oral Form				
Rabies				
Typhoid Fever, Injected Form				
Typhoid Fever, Oral/by Mouth Form				
Yellow Fever				

Have you ever had a serious reaction to any vaccination or gamma globulin? \_\_\_\_\_

If yes. Please describe: \_\_\_\_\_

## Questions for Women

Are you pregnant, suspect you may be pregnant, or trying to become pregnant?    Yes    No

Do you have any special concerns or questions? \_\_\_\_\_

\_\_\_\_\_

