FreedomUrgentCare

SETON MEDICAL CENTER HARKER HEIGHTS

# TRAVEL MEDICINE QUESTIONNAIRE

Patient Name:

DOB:

**CLEARLY PRINT ALL INFORMATION**

(This form should be completed by the patient and brought to their Travel Immunization appointment)

| | | |
|---|---|---|
| Legal Name of Traveler: | | |
| Home Address: | | |
| City: | State: | Zip: |
| Home Phone: | Business Phone: | |
| Primary Care Physician: | Phone: | |
| Emergency Contact: | Phone: | |
| Relationship: | | |

**ITINERARY**

| | | |
|---|---|---|
| Departure Date: | Return Date: | Length of Trip: |

**PURPOSE OF TRAVEL**

| | | | | |
|---|---|---|---|---|
| ☐ Business | ☐ Field Work | ☐ Relocation | ☐ Teaching/Study | ☐ Missionary Work |
| ☐ Vacation | ☐ Diving | ☐ Safari | ☐ Climbing | ☐ Other |

**TYPE OF TRAVEL**

| | | |
|---|---|---|
| ☐ Group/Tour | ☐ Independent | ☐ Fixed Itinerary |
| ☐ Flexible Itinerary | ☐ Cruise | ☐ Other: |

**ACCOMMODATIONS**

| | | | | |
|---|---|---|---|---|
| ☐ Compound | ☐ Hotel/Resort | ☐ Private/Rented Home | ☐ Cruise Ship | ☐ Off Shore Rig |
| ☐ Dormitories | ☐ Camping | ☐ Enclosed Beach Housing | ☐ Orphanages | ☐ Staying or eating with local families |

**LIVING ACCOMODATIONS**

☐ Screening ☐ Mosquito Netting ☐ Air Conditioning

**DESTINATION, INCLUDING AIRPORT STOPOVERS, IN ORDER OF TRAVEL**

| COUNTRY | CITY | DURATION | URBAN | RURAL |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Patient Name: _____DOB: _____ SSN:_____

**IMMUNIZATION HISTORY**: (Check "had disease" if applies or list date of vaccine in appropriate box)

| | Had Disease | Vaccine #1/Date | Vaccine #2/Date | Vaccine #3/Date | Not Known |
|---|---|---|---|---|---|
| Chickenpox (Varicella) | | | | | |
| Hepatitis A | | | | | |
| Hepatitis B | | | | | |
| Influenza | | | | | |
| Japanese Encephalitis | | | | | |
| Measles | | | | | |
| Mumps | | | | | |
| Pneumococcal | | | | | |
| Polio | | | | | |
| Rabies | | | | | |
| Rubella | | | | | |
| Tetanus/Diphtheria | | | | | |
| Typhoid Injection | | | | | |
| Typhoid Oral | | | | | |
| Yellow Fever | | | | | |

Do you have an "International Certificate of Vaccination"? □ YES □ NO

Have you ever fainted or had an adverse reaction to any:

Vaccines? □ YES □ NO | Bee Stings? □ YES □ NO

| | |
|---|---|
| Do you have cancer, leukemia, AIDS, or other immune system problems? | □ YES □ NO |
| Do you take Cortisone, Prednisone, other steroids, anti-cancer Drugs, Antivirals or had radiation therapy? | □ YES □ NO |
| Have you received a blood transfusion, blood products or immune globulin in the past year? | □ YES □ NO |
| Have you had any immunizations in the past 4 weeks? | □ YES □ NO |

Explain YES answers:

**HEALTH HISTORY**

| Weight: | Height: | Allergies: |
|---|---|---|

**MEDICATIONS**: (List all medications, including dosages)

| Prescription: | Non – Prescription: |
|---|---|
| | |
| | |
| | |
| | |
| | |

Medical Conditions:

Previous Surgery:

| | | |
|---|---|---|
| Nightmares: □ YES □ NO | Psoriasis: □ YES □ NO | Seizure/Epilepsy: □ YES □ NO |
| Psychiatric Disorders/Depression: □ YES □ NO | Stomach/Colon Problems: □ YES □ NO | |

**Women**: Type of contraception _____(give name brand)

| | | |
|---|---|---|
| Pregnant? □ YES □ NO | Planning Pregnancy within 3 months?□ YES □ NO | Nursing? □ YES □ NO |

I verify that the above information is complete and correct to the best of my knowledge.

_____ _____

Signature Date