Travel Questionnaire

Please bring these completed forms, all immunization records, and a complete list of medications with you to your visit.

**Personal Information:**
Name: _________________________________ Date of Birth: ____________ Age: ____ Gender: __M  __F  __Other
Email Address: __________________________Primary Care Physician (PCP): _________________________________
Referred by: __ UA  __ Health Dept  __ Physician/PCP  __ CDC  __ Website  __ Family or Friend  __ Other

**Travel Information:**
Please list the cities/ports and countries to which you are traveling in the order you will visit them. Include all stopovers. List dates of travel.

<table>
<thead>
<tr>
<th>Cities/Ports and Countries</th>
<th>Length of Stay in each Location</th>
<th>Type of Accommodation</th>
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**Purpose of travel** (check all that apply):
__ Pleasure/vacation
__ Business (type): ______________________________
__ Education/research
__ Moving/relocating
__ Visit family/friends
__ Volunteer/service/mission/humanitarian
__ Adoption
__ Obtain medical/dental care
__ Other: ______________________________

**Activities During Travel** (check all that apply):
__ Cruise ship
__ Camping
__ Hiking or trekking
__ Bicycling or motorcycling
__ Caving
__ Potential new sexual partners
__ High altitude (>8000 ft)
__ Swimming (specify type of water):
  __ Chlorinated pool
  __ Fresh water, lake or stream
  __ Ocean
__ Scuba diving
  Certified: __ No  __ Yes
  Time to air travel after last dive: ___ hrs/days
__ Visit jungle area
__ Visit rural area or village
__ Visit farm
__ Work with animals
__ Work at orphanage
__ Medical or dental work (exposure to bodily fluids)
__ Be outdoors during evening or nighttime hours
__ Other: ______________________________
Medical Information:

Allergies:
Are you allergic to any of the following?

__ Latex
__ Gelatin
__ Eggs
__ Nuts
__ Fish
__ Shellfish
__ Bee/wasp stings
__ Sulfa drugs
__ Penicillin
__ Neomycin or streptomycin
__ Thimerosal/mercury
__ Other: _____________________________________

Do you need an Epi-pen for any of your allergies? __ No __ Yes

Medical History:
Please check the box if you have or have had any of the following:

__ Eye or ear problems
__ Skin conditions, psoriasis, eczema
__ Heart murmur, rheumatic fever, congenital heart disease
__ Heart disease, heart attack, angina, stroke
__ Arrhythmia, hypertension, heart failure
__ Artificial heart valve, pacemaker or defibrillator, heart surgery (stents or bypass)
__ Respiratory disease, emphysema, asthma, hay fever
__ Smoked in the past 10 years (cigarettes, cigars, pipes, marijuana, hookah, e-cig/vape)
__ Problems with your thymus (different than thyroid), such as myasthenia gravis or DiGeorge syndrome
__ Diabetes or thyroid disease
__ Liver disease, hepatitis, jaundice, cirrhosis
__ Reflux, GERD, ulcers, IBS, Crohn’s, ulcerative colitis
__ Kidney disease, dialysis
__ Drug addiction, alcoholism
__ Seizures or epilepsy
__ Fainting or dizzy spells
__ Nervousness, anxiety, depression
__ Guillain-Barre syndrome
__ Vivid dreams or nightmares
__ Other psychological conditions
__ Arthritis, rheumatoid arthritis, fibromyalgia
__ Bruise easily, bleeding problems (anemia, sickle cell)
__ Active cancer, leukemia, lymphoma or immune deficiency disease
__ Receiving cancer chemotherapy, immunosuppressive therapy, radiation, prednisone
__ Organ, bone marrow, or stem cell transplant
__ HIV disease or AIDS
__ Positive TB skin test, treatment for tuberculosis
__ Received immunoglobulin, blood transfusion, or blood products in the last 12 months
__ Spleen removed
__ Fever or antibiotics in the last 7 days
Motion sickness

Other medical conditions not listed above: ____________________________

Previous travel-related illnesses (please explain): ____________________________

Females Only:

Are you breastfeeding now?  __ No  __ Yes

Last menstrual cycle (first day/date): ________________________________  __ I do not have menstrual cycles

Contraception/birth control method:  __ None  __ Condoms  __ Pills  __ IUD  __ Implant

__Other: ___________________________________________________________________________________

Are you pregnant now?  __ No  __ Yes  __ Maybe

If yes, how many weeks? ________________________________

If no, is there a reason why you could not be pregnant now (uterus was removed; don’t have sex with men, etc.):

___________________________________________________________________________________________

Are you planning to become pregnant during your trip or within 6 months following?  __ No  __ Yes

If yes, when? ________________________________________________________________________________

Medications:

Please list all antibiotics, steroids/prednisone, chemotherapy, prescription medications, herbals, vitamins, and over-the-counter or nonprescription medications:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Instructions</th>
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Vaccination Reactions:

What meal(s) have you eaten so far today?  __ Breakfast  __ Lunch  __ Snack  __ Nothing

Have you ever ... fainted or felt light-headed from a shot?  __ No  __ Yes

fainted or felt light-headed from having blood taken?  __ No  __ Yes

had any unusual reaction to a vaccine?  __ No  __ Yes

Describe: ______________________________________________________________________

Vaccination History:

Did you have all your childhood vaccinations?  __ No  __ Yes  __ Not sure

Did you attend college or university in the USA?  __ No  __ Yes  __ What years? ________________

Where were you born?  __ USA  __ Other country ________________
If you were born outside the USA:

At what age did you arrive in the USA? ____________

Did you get vaccines for immigration? __ No __ Yes __ Not sure

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Yes/No</th>
<th># Doses</th>
<th>Dates</th>
<th>Had the Disease? Yes/No</th>
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<tbody>
<tr>
<td>Influenza (Flu)</td>
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<tr>
<td>Measles/Mumps/Rubella</td>
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<tr>
<td>Hepatitis A</td>
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<td>Hepatitis B</td>
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<td>HPV</td>
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<tr>
<td>Pneumonia 13/15/20/23</td>
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<td>Covid-19 Pfizer/Moderna/J&amp;J</td>
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<td>Varicella (Chickenpox)</td>
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<td>Zoster (Shingles)</td>
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Vaccine | Yes/No | Last Dose (Year) | Vaccine Type
---------|--------|------------------|-----------------|
Tetanus Booster (as adult) | __ | Td | __ Tdap
Polio Booster (as adult) | __ | | |
Typhoid | __ Oral (pills) | __ Injection (shot)
Meningococcal | __ MCV4 | __ MenB
Japanese Encephalitis | |
Rabies | |
Yellow Fever | |

The above information is correct to the best of my knowledge. I understand that some vaccines can cause serious or deadly illness when administered to someone infected with HIV, or who is immunosuppressed or pregnant. I have received written immunization information, all questions have been answered to my satisfaction, and I give my consent to receive recommended immunizations. I will not hold University Medical Center or its staff responsible for any errors or omissions that I may have made in completing this form.

Patient Signature _________________________________________________________  Date ____________________

Parent/Legal Guardian Signature ____________________________________________  Date ____________________

Travel Medicine Provider __________________________________________________ Date ____________________