International Travel Medical Questionnaire

Name: _____ **Date of Birth:** _____/_____/_____

Age: _____ ☐ Male ☐ Female **Smoker**: ☐ Yes ☐ No

Date of Departure: _____ **Return Date:** _____

ITINERARY:
Please list all countries in the order of travel (including layovers greater than 12 hours). *Prescriptions for illness prevention and treatment vary based on this information.*

_____

_____

Reason for travel: (Check all that apply):

☐ pleasure ☐ visiting friends/relatives ☐ business ☐ mission ☐ school ☐ cruise

Do you plan to visit? (Check all that apply):

☐ urban areas ☐ rural areas/jungle ☐ high altitude regions above 8000 feet (2500 meters)

MEDICAL HISTORY: List current or significant past medical history. Please include any recent illness for which you have completed treatment:

_____

_____

SURGICAL HISTORY:

_____

_____

MEDICATION LIST: Include all prescription and over the counter medication.

_____

_____

ALLERGY TO MEDICATION/VACCINES/LATEX/EGGS:

_____

Females Only:
Are you pregnant now or might you become pregnant within the next 3 months? ☐Yes ☐No
Are you breastfeeding? ☐Yes ☐No

Traveler Signature: _____ **Date:** _____
Name: _____ **Date of Birth:** _____/_____/_____

FOR CLINICIAN USE ONLY:

Patients receiving vaccines:
Are you immune compromised? ☐ Yes ☐ No
Have you ever fainted from having your blood drawn or from an injection? ☐ Yes ☐ No
LMP: _____

Patients requiring Yellow Fever:
Thymus gland removed or a history of problems with thymus, such as myasthenia gravis, DiGeorge syndrome, or thymoma? ☐ Yes ☐ No

Patients requiring malaria prophylaxis:
History of seizures? ☐ *Yes* ☐*No* Psychiatric disorder? ☐ *Yes* ☐ *No* Psoriasis History? ☐ *Yes* ☐ *No*

G6PD deficiency? (If prescribing Chloroquine, Primaquine) ☐Yes ☐ No

Malaria medication taken in past? ☐*Yes* ☐*No* Name of Medication_____

Any side effects? ☐*Yes* ☐*No* If yes, please list_____

OBJECTIVE: Temp_____ Pulse_____ B/P_____ Weight _____

Provider notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Provider Signature: _____ **Date:** _____

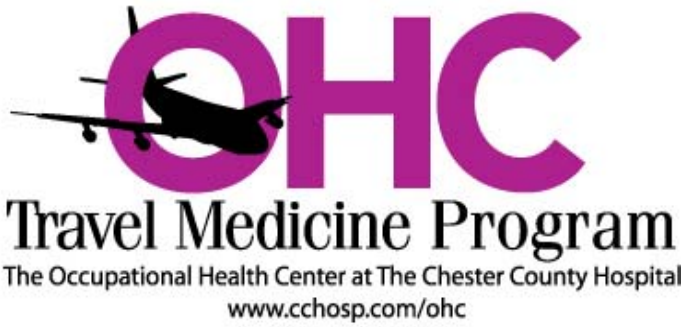
Name: _____ **Date of Birth:** _____/_____/_____

IMMUNIZATION HISTORY: ☐ Copy attached

Attach copy or fill out.

Immunizations	Please circle			Vaccine Dates
DPT/Td (Tetanus) series completed?	Yes	No	Most recent booster (Td or Tdap):	
Polio series completed?	Yes	No	Adult booster date:	
Measles (rubeola) Have you had the disease?	Yes	No	Measles Vaccine Dates:	#1: #2:
Mumps Have you had the disease?	Yes	No	Mumps Vaccine Dates:	#1: #2:
Rubella (German measles) Have you had the disease?	Yes	No	Rubella Vaccine Dates:	#1:
Varicella (chicken pox) Have you had the disease?	Yes	No	Varicella Vaccine Dates:	#1: #2:
Hepatitis A Have you had the disease?	Yes	No	Hepatitis A Vaccine Dates: Immune Globulin Date:	#1: #2:
Hepatitis B Have you had the disease?	Yes	No	Hepatitis B Vaccine Dates:	#1: #2: #3:

Immunizations	Date of Vaccine Administration
Influenza Vaccine	
Pneumococcal	
Typhoid: *oral or injectable*	
Yellow Fever	
Japanese Encephalitis:	#1: #2: #3:
Meningococcal	
Rabies	



Registration Information

Today's Date: _____

Personal Information

Last Name: _____ **First Name:** _____ **M.I.:** _____

Street Address: _____

City/Town: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____-_____-_____ **Cell Phone:** _____-_____-_____

Emergency Contact: _____ **Phone:** _____-_____-_____

Social Security #: _____-_____-_____ **Date of Birth:** _____

Sex (please circle): **Male** **Female**

Race (please circle): **Caucasian** **Black** **Hispanic** **Asian** **Other**

Have you been seen at The Occupational Health Center before? Yes ___ No___

If yes, please circle the location where you were seen:

West Chester **OR** **Kennett Square**

Employer Information (complete this section for business travel only)

Company: _____

Street Address: _____

City/Town: _____ **County:** _____

State: _____ **Zip Code:** _____ **Phone:** _____-_____-_____

Company Contact: _____ **Title:** _____