

**Travel Medical Questionnaire**

<b>Immunizations</b>	<b>Yes</b>	<b>No</b>	<b>Problems</b>
Have you ever fainted from having your blood drawn or from an injection?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a fever from vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had <i>any</i> bad reaction/side effect from any vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had hepatitis A or B vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you live (or work closely) with anyone who has HIV/AIDS or other immune disease or is on cancer chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you received any injection of immune globulin or any blood product in the past 8 months?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>General Medical</b>			
Do you have a medical condition that needs medication or physician follow-up?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a medical condition that is stable now but that may recur while traveling?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a fever in the past 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have HIV/AIDS, any other immune disorder, or cancers?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have severe thrombocytopenia (low platelet count) or a clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a convulsion, a seizure, or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any stomach problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had hepatitis or yellow jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of psychiatric or emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a problem with strange dreams and/or nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Women Only</b>			
Are you pregnant or might you become pregnant on this trip?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>	
Date of your last menstrual period:			
Method of birth control:			
Do you have problems with vaginitis?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you on Hormone Replacement Therapy?	<input type="checkbox"/>	<input type="checkbox"/>	

**Travel Medical Questionnaire**

<b>Medications</b>	<b>Yes</b>	<b>No</b>	<b>Problems</b>
ARE YOU TAKING OR WILL YOU BE TAKING:			
Quinine, quinidine, or medication for a heart conduction problem?	<input type="checkbox"/>	<input type="checkbox"/>	
Steroids, prednisone, or cortisone?	<input type="checkbox"/>	<input type="checkbox"/>	
Antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	
Pepto-Bismol to prevent traveler's diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	
Antacids?	<input type="checkbox"/>	<input type="checkbox"/>	
List all medication (and treatment) you are taking on a regular basis. (Please Print)			
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
<b>Allergies</b>	<b>Yes</b>	<b>No</b>	<b>Problems</b>
ARE YOU ALLERGIC TO:			
Any food?	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin or sulfa?	<input type="checkbox"/>	<input type="checkbox"/>	
Any other medication?	<input type="checkbox"/>	<input type="checkbox"/>	
Bee stings or insect bites?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of hives or urticaria?	<input type="checkbox"/>	<input type="checkbox"/>	

**Comments or Additional Questions:**

**Nurse's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_